UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

STEVEN BRODER,

Plaintiff,

vs.

File No. 03-CV-75106

CORRECTIONAL MEDICAL SERVICES, INC., *et al.,*

Hon. Gerald E. Rosen
U.S. Mag. Judge Paul J. Komives

Defendants.

MICHIGAN CLINICAL LAW PROGRAM
By: Paul D. Reingold (P-27594)
Attorneys for Plaintiff
363 Legal Research Building
801 Monroe Street
Ann Arbor, MI 48109-1215
(734) 763-4319

Kevin Thom (P-36178)
Assistant Attorney General
Attorney for Defendants Caruso, Pramstaller, and Epp
Corrections Division
P.O. Box 30217
Lansing, MI 48909
(517) 335-7021

CHAPMAN AND ASSOCIATES, P.C.
Ronald W. Chapman (P-37603)
Brian J. Richtarcik (P-49390)
Attorneys for Defendants Hutchinson and Mathai
40950 North Woodward Ave., Suite 120
Bloomfield Hills, MI 48304
(248) 644-6326

PLAINTIFF'S BRIEF IN RESPONSE TO MDOC DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Table of Contents

Statement of Issues Presented

1. Did the Michigan Department of Corrections' policies and procedures, as conceived, implemented, approved, and/or tolerated by its chief medical officer and its regional health care administrator, violate Mr. Broder's Eighth Amendment rights, and were those policies and procedures a proximate cause of the delay in diagnosis and treatment of Mr. Broder's throat cancer?

The plaintiff says yes.

2. Are there genuine issues of material fact, and could a reasonable jury find in the plaintiff's favor, as to question #1?

The plaintiff says yes.

3. Is the plaintiff entitled to damages and injunctive relief on his claims, despite the defenses of administrative exhaustion, the Eleventh Amendment, and qualified immunity?

The plaintiff says yes.

The Legal Standard and Controlling Authority

To prevail on his Eighth Amendment claim, the plaintiff must show that the defendants were deliberately indifferent to his serous medical needs. See *Estelle v. Gamble,* 501 U.S. 294 (1991); *City of Canton v. Harris*, 489 U.S. 378, 392 (1989). In this context, deliberate indifference can be shown by proof that policy makers were aware that inmates faced a substantial risk of serious harm and disregarded the risk by failing to take reasonable measures to abate it. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

To be granted summary judgment, 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).

TABLE OF AUTHORITIES

Cases

Proceedings to Date

The plaintiff filed this action under 42 U.S.C. § 1983 on December 24, 2003. As to the senior Michigan Department of Corrections (MDOC) officials who are bringing this motion, Mr. Broder alleged that their medical *policies and procedures* violated his Eighth Amendment rights by causing the late diagnosis and treatment of his throat cancer. Mr. Broder filed an amended complaint (unchanged as to the MDOC defendants) on December 8, 2004, and the defendants answered.

After some service delays, and motions by other parties, discovery ensued. Following discovery, in September 2006, the parties stipulated to the dismissal of one of the MDOC defendants (warden Henry Grayson). With discovery concluded, the MDOC defendants moved for and got an extension of time to file their summary judgment motion, from November 30 to December 15, 2006. They filed their motion on December 19, 2006. Mr. Broder now files this timely response.

Statement of Facts

The relevant facts are set forth in detail in paragraphs 4-65 of the plaintiff's experts' reports, attached as Exhibits A and B to the plaintiff's earlier response brief.[1] Because the core issue on summary judgment is whether or not the facts – taken in the light most favorable to the plaintiff – are sufficient for a reasonable jury to find in Mr. Broder's favor on his Eighth Amendment claim, instead of duplicating the facts here, the plaintiff will incorporate them into his argument, as he did in response to the CMS defendants' motion. *See* Argument, Part I, below.

[1] Rather than create an additional set of exhibit books for this motion, the plaintiff will use and rely upon the exhibits he filed in support of his brief opposing the CMS defendants' motion for summary judgment. To the extent that additional exhibits are necessary, he will attach them to this brief (using exhibit numbers instead of letters). To distinguish the three defendants bringing this motion from the CMS defendants who filed earlier, Mr. Broder will refer to these defendants as the MDOC defendants.

ARGUMENT

Introduction

As the Court knows, this case involves the late diagnosis and treatment of throat cancer by Mr. Broder's primary care physician (PCP) and the prison medical system. Dr. Bency Mathai admits that as of 8/20/01 she suspected that Mr. Broder had cancer. Although his cancer would have been detectable and could have been confirmed by tests at that time, she failed to get a confirmed diagnosis of throat cancer until *five months later*, and failed to start any treatment until almost *eight months later*. As a result, Mr. Broder spent months of constant pain and anxiety, had to undergo more invasive treatment, and suffered permanent harm as a result of the more invasive treatment. He also has a much lower chance for survival if his cancer recurs. For purposes of the MDOC defendants' motion, Mr. Broder alleges that the failure of care was not only the fault of the PCP who failed to coordinate and to monitor his care, but also the fault of the MDOC /CMS health care system, which he maintains all but guaranteed the late diagnosis and treatment.

Mr. Broder says that Dr. George Pramstaller, the MDOC's chief medical officer, and Jan Epp, its regional health care administrator, were responsible for the systemic failure of care that proximately caused the delay in the diagnosis and treatment of his cancer.[2] These defendants had little direct contact with Mr. Broder (although there is evidence that both were aware of his case). But the primary claim is that they were ultimately responsible for the provision of health care services for Michigan prisoners at the Parnall Correctional Facility. At all relevant times they were responsible for the medical *policies and procedures* governing Mr. Broder's care.

---

[2] The defendants are correct that the current MDOC director, Patricia Caruso, cannot be individually liable for the medical policies and procedures that pre-dated her directorship. Accordingly, only the claim for injunctive relief is appropriate as to her. For purposes of injunctive relief (to prevent a recurrence of a failure of specialty/urgent care), defendants Caruso and Pramstaller remain as appropriate defendants, while defendant Epp – who has retired – can only be sued for her past acts or omissions.

These defendants need not have intended to harm Mr. Broder to be held liable under the Eighth Amendment. Nor does Mr. Broder make a *respondeat superior* claim as to them. His claim is that the policies and procedures they conceived, implemented, approved, or tolerated were a proximate cause of his late diagnosis and treatment. The delays caused extra and unnecessary pain and suffering, plus permanent harm as a result of the more invasive treatment that became necessary because of the delays.

The defendants' motion should be granted only if there are no genuine issues of material fact, taking all the evidence in the light most favorable to the plaintiff. Because there are a host of factual questions, and because a reasonable jury could find in Mr. Broder's favor on his Eighth Amendment claim, the MDOC defendants' motion for summary judgment should be denied.

I. THE EIGHTH AMENDMENT CLAIM

A. The Operative Facts[3]

In 2001-02, to see medical staff, prisoners had to fill out a form (a medical "kite") or ask cellblock staff to contact health services on their behalf. Exh. O, at 42; Exh. G, at 23-27, 52, 59. So-called "mid-levels" – nurses, nurse practitioners, and physicians' assistants – then reviewed the kites and provided much of the care. Exh. H, at 13; Exh. I, at 19. At the Parnall Correctional Facility, there was just one primary care physician for *c.* 1,200 inmates. Exh. H, at 15; Exh. I, at 11. During 2001-02, Dr. Pramstaller was the MDOC's chief medical officer and Ms. Epp was the regional health care administrator responsible for medical care at Parnall. Exh. F, at 8-9, and Exh. 1.

[3] Although Part I of this brief contains many of the same facts and arguments as the plaintiff's brief in response to the CMS defendants' motion for summary judgment, it has been re-written to respond to the arguments raised by the MDOC defendants. As to both sets of defendants, the evidence supports Mr. Broder's contention that his Eighth Amendment rights were violated. He re-describes the operative facts in detail (though with a different focus) to make that point as strongly as possible.

Mr. Broder recalls first describing his symptoms to medical staff in April of 2001. Exh. G, at 50, 98, 106, 110. The earliest record in his medical chart of a sore throat is 5/4/01. Exh. C, at 19. Mr. Broder's sore throat did not go away. Although he was given an appointment to return to the clinic in a month, the return visit was cancelled, and he did not see his doctor again for 2½ months. Exh. G, at 102; Exh. C, Chart, at 19.

In the meantime, on 7/11/01, at his annual health care screening, he again presented with throat-related problems – ongoing sinus issues and a cough lasting more than three weeks. Exh. C, at 18. He was also worried about the fact that he was losing weight, which is reflected in the annual screening sheet. Exh. C, at 18; Exh. D, at 3. He was not referred to a physician. He continued to try (without success) to schedule a physician visit by filing kites, but the visits either were not scheduled or were cancelled. Exh. G, at 101-02; Exh. E, Letter of 8/18/01; Exh. C, at 17 (visit 8/3/01 cancelled).

On 8/18/01 he wrote a letter to health services. He described his ongoing problems as: "(1) sinus drainage and sore throat, and (2) the drastic loss of weight. The sinus problem started in about March and has not gotten any better. In fact, now it is becoming hard to swallow." Exh. E, Letter 8/18/01. He finally saw Dr. Mathai (for the first time since 5/4/01) on 8/20/01. A reasonable jury could find that Mr. Broder's inability to get a physician visit from early May until late August 2001 – despite having persistent sinus/throat issues and significant weight loss, and despite his ongoing efforts to do so – was due to the policies and procedures that governed when and how a prisoner could access a doctor, and/or to the fact that only one doctor was available to serve *c.* 1,200 prisoners.

Dr Mathai claims that she suspected Mr. Broder might have cancer on 8/20/01. Exh. H, at 48-49. She says that she was concerned about his weight loss and that she wanted to rule out

prostate problems, colon or lung cancer. *Id.* She therefore did a prostate exam and ordered a chest x-ray. *Id.,* Exh. C, at 17.

She did *not*, however, enter her suspicions into the file. Exh. C, at 17. Moreover, she did not fill out a chest x-ray form, or if she filled out a form, she did not ensure that the test occurred. She admitted that in 2001 the only *system* for ensuring that such a test had occurred was to check at the next scheduled visit. Exh. H at 81, 86. CMS's Michigan director, Dr. Craig Hutchinson, concurred that the "next-visit" protocol was the accepted method or "tickler system" by which prison medical staff kept tabs on their patients' medical needs. Exh. I, at 48-49.

Dr. Mathai did not schedule the next visit for 60 days. Exh. C, at 17. Thus, if the lung cancer screen (the chest x-ray) were not performed for *any* reason, she would not catch the failure, and could not begin the process of getting that test re-scheduled – or other tests initiated – for at least 60 days. Exh. H, at 81; Exh. J, at 9; Exh. O, at 41. And if someone else happened to be on duty at that return visit, by looking at the file, the substituting doctor would not be able to discern that Dr. Mathai had done the prostate exam or had ordered the chest x-ray *to screen for cancer*, because there was no such chart entry. Exh. C, at 17.

As noted in response to the CMS defendants' motion, a reasonable jury could find either (1) that Dr. Mathai did not suspect cancer on 8/20/01 and lied in her deposition to cover up her mistake – when in fact she only did a routine prostate exam and only ordered the chest x-ray because of Mr. Broder's high WBC count, or (2) that *if* Dr. Mathai suspected cancer, her failure to chart her suspicions, to procure the chest x-ray, to discover that the chest x-ray was never performed, and to have a process in place to catch such a mistake if it occurred, amount to deliberate indifference under the Eighth Amendment. A reasonable jury could also find that the MDOC's failure (1) to require that a prison doctor chart her suspicions of cancer, (2) to have an effective

tickler system in place, (3) to catch that a lab test was wanted but never procured, and (4) to re-test or to initiate new tests for cancer sooner than 60 days later at the earliest, also amount to deliberate indifference to the serious medical needs of a cancer patient.

Dr. Mathai also had reason *from the medical file* to be concerned about the weight loss. Mr. Broder's weight at his annual health screening on 7/11/01 was 156. At that time he told the nurse that he had been on the (lower calorie or less appetizing) kosher diet line, but that he had gone back to the regular diet line and had put on 8 pounds in two weeks. Exh. C, at 18. He was thus off the kosher diet and back on the regular diet by no later than 6/28/01. When he saw Dr. Mathai on 8/20/01, he had been off the problematic diet for almost eight weeks. Nevertheless, his weight had dropped six more pounds, to 150. Exh. C, at 17. Accordingly:

Q. If [Mr. Broder] complained of continued weight loss as of the end of August, we could not attribute it to the kosher diet line, based on what's in the chart?
A. I would agree.

Exh. O, Defense Expert Norman, at 30-31; Exh. M, at 102 (weight loss remained "unexplained" based on the medical record). Dr. Mathai never observed (or never charted) that Mr. Broder was *still losing weight* despite having been back on the regular diet for nearly two months. Exh. C.

A reasonable jury could find that the failure to have a system in place to record critical information in the file – or to make sure that its significance was apparent – amounts to deliberate indifference. A reasonable jury could also find that having one physician for 1,200 patients made every patient interaction cursory, and led to the failure to locate, or to apprehend the significance of, the weight-loss information that *was already in the file*.

The plaintiff's experts say that by 8/20/01 Dr. Mathai had ample information in the file (and from the patient) to suspect *throat* cancer (in addition to prostate/colon or lung cancer) and to test for it. Exh. M, at 39-40; Exhs. 1 & 2, ¶¶ 61-70. She claims that she was unaware at that

point that he was having difficulty swallowing, a key indicator of throat cancer. Exh. H, at 68; Exh. C, at 17. The evidence, however, shows that Mr. Broder had described in detail his sore throat since the spring, his weight loss, his increasing pain, *and his difficulty in swallowing*, in his letter dated 8/18/01. Exh. E. A reasonable jury could find that a patient who took the time to write down his symptoms two days before a visit to his PCP would describe those symptoms to her – as he says he did, *see* Exh. G, at 100, 110-11 – despite the incomplete entry in the medical record.[4]

More importantly, on 8/31/01 – 11 days *after* his visit with Dr. Mathai – Mr. Broder sent a follow-up kite to health services. In it he said, "An existing problem with throat pain remains. ... This problem has existed since approximately March. ... Since this time it has become *difficult and painful to swallow.*" Exh. E, 8/31/01 Kite. We know that the kite was received and logged in by health services. *Id.* The defendant's expert on prison medical care testified that when the information in the kite is important to a diagnosis, it must be added to the patient's medical record. Exh. 0, at 44-45. It was not. Exh. C.[5] In fact, none of the contents of any of Mr. Broder's written complaints – his letter of 8/18/01, or his grievance of 8/31/01, or his kite of 8/31/01 – ever made it in to his medical file. If his doctor did not know that he was having difficulty swalowing, it was not for Mr. Broder's lack of trying to tell her. *Id.* A reasonable jury could find

[4] The CMS defendants' counsel made this point at Mr. Broder's deposition – that having written down his symptoms on a certain day, it would only be logical that he would report those same symptoms to his PCP at his next visit. Exh. G, at 111-12.

[5] On 8/31/01, Mr. Broder also prepared a formal grievance describing the same symptoms. He wrote, "This throat problem should have been corrected by this time and I should not have been subjected to intolerable pain, especially when weight loss and [a] high-blood pressure problem has also arisen during the same time frame." Mr. Broder believes that he filed the grievance, though it was never answered – not an uncommon occurrence. Exh. G, at 74-77. Also, in a grievance he filed on 11/3/01, he noted that an earlier grievance "was either misplaced or lost, as I have not received any receipt or response." Exh. E, 11/3/01 Grievance.

that the failure to have a system in place to get critical diagnostic information from the patient to his doctor (or in to his medical file) amounts to deliberate indifference to his medical needs.

Furthermore, in late August and early September 2001, Mr. Broder came in to the clinic almost daily for a series of blood-pressure checks. For those visits the nursing notes show steady complaints and/or assessments of ongoing throat problems. Exh. C, at 15-16.

Accordingly, based on what Mr. Broder says he told his doctor, and based on the letter he wrote on 8/18/01, the kite he submitted on 8/31/01, the grievance of 8/31/01 (*see* n. 5), and the follow-up clinic visits, a reasonable jury could find that Dr. Mathai had all the information she needed to make a differential diagnosis of *throat* cancer and to screen for it. Yet she failed to include throat cancer as a differential diagnosis; she failed to get the chest x-ray to screen for lung cancer; and she failed to chart her suspicions of cancer at all. Even after Mr. Broder's kite of 8/31/01and his unabated throat problems in early September, Dr. Mathai still did not screen for throat cancer. Exh. C. Reviewing his chart on 9/11/01, she failed to note that his chest x-ray had never been scheduled or performed, and she ordered no other tests to rule out cancer. Nor did she take further steps to monitor his weight. *Id.* A reasonable jury could find that the lack of any *system* to bring an accurate description of his symptoms to his doctor's attention, combined with the lack of a working tickler system and the lack of staff, were a proximate cause of the late diagnosis of his cancer, and amount to deliberate indifference to his serious medical needs.

On 9/23/01, Mr. Broder wrote directly to Dr. Pramstaller, the chief medical officer for the MDOC. Mr. Broder said,

> In approximately March of this year, during a scheduled visit at health care I had appraised [*sic*] the doctor of sinus problems and a problem with a sore throat. The sinus problem was corrected, however, the throat pain and soreness has increased. In July during my annual health screening, once again, health care was appraised [*sic*] of the difficulty in swallowing and the drastic loss of weight. Blood tests were taken, along

> with bi-weekly blood pressure checks. The throat pain remains, as does the difficulty swallowing.

Letter 9/23/01, Exh. E. This information, too, never made it into Mr. Broder's file. Exh. C.[6]

On 10/12/01, Dr. Audberto Antonini, a visiting physician, filled in for Dr. Mathai, who was on vacation. Dr. Antonini noted Mr. Broder's "weight loss of 20 pounds [and] progressive dysphagia since April, sore throat and hoarseness, ... and general malaise." Dr. Antonini immediately suspected stomach or throat cancer. Exh. C, at 13-14. He filled out referral forms to get approval for specialty care to rule out throat or stomach cancer. He marked the forms as "urgent" and he faxed them to CMS for approval the same day. Exh. D, at 10-11. He also requested another blood panel "in 2 weeks" as well as diagnostic tests, including a barium swallow and a chest x-ray. Exh. D, Physician's Orders, at 9 & 10.

Dr. Antonini said that when he wrote "urgent" on the referral forms on 10/12/01 he "was expecting all this to happen within a month, everything." That is, Dr. Antonini expected to get an *answer* – a yes or no on the cancer *diagnosis* – within 30 days. Antonini Dep., Exh. J at 21. A reasonably jury could find that the *system's* inability to get a confirmed diagnosis from mid-October 2001 until mid-January 2002 – despite the requesting doctor's opinion that a diagnosis

---

[6] After learning that there was evidence tying Dr. Pramstaller directly to Mr. Broder, the defense tried to cast doubt on the authenticity of the letter and the response. *See* MDOC Defendants' Brief, at 6, n. 10. As to Dr. Pramstaller's liability based on his responsibility for the MDOC/CMS policies and procedures, his personal knowledge of Mr. Broder's case is irrelevant. *See* Part I(B), *below*. As to his liability based on such personal knowledge, the MDOC defendants simply raise a new fact question: a reasonable jury could conclude that the letter was sent and answered exactly as Mr. Broder described. Exh. G, at 38-41; Exh. E, Letter & Response. Moreover, if the letter was sent and received, what this means is that even when the MDOC's chief medical officer made personal inquiries to the providers at the facility, there *still* was no system in place to make sure that Mr. Broder's cancer was diagnosed and treated within the requirements of the Eighth Amendment – which only strengthens his policy-and-practice claim.

should be completed within 30 days – is deliberate indifference under the Eighth Amendment.[7]

The duty to follow-up with Mr. Broder's care reverted to Dr. Mathai. Exh. J, at 7-10, 12. It was she who had to make sure that the "urgent" consults and diagnostic tests were timely completed. *See* Defense Counsel's Questions, Exh. G, at 93-94; *see also* Antonini Dep., Exh. J, at 32-35. On 11/1/01, Dr. Mathai reviewed Mr. Broder's chart. All that she wrote was that he was "currently being evaluated for weight loss." Exh. C, at 12. From this entry, it appears that she was yet unaware that Dr. Antonini had suspected throat or stomach cancer on 10/12/01 and had made urgent referrals for both.[8] A reasonable jury could find that as of 11/1/01, Dr. Mathai did not know that Mr. Broder was being evaluated for cancer, because she only looked at the chart in a cursory way. A reasonable jury could find that a doctor who knew that her patient had been urgently referred to specialists for testing for throat or stomach cancer would not refer to the problem as "currently being evaluated for weight loss" and would not list her sole follow-up task as repeating the routine lab work for the (unrelated) elevated white blood count. Exh. C, at 12. A reasonable jury could also find that the policies and procedures in place to *inform* a vacationing doctor of the urgent needs of her patients upon her return, so that timely follow-up would occur, were essentially non-existent in the fall of 2001 at Parnall.

There is no indication in the medical chart that Dr. Mathai took any concrete steps to speed the processing of the urgent ENT/GI specialty care visits or the diagnostic tests that had

---

[7] As to the diagnostic tests, one of them – the barium swallow – was scheduled for 10/19/01, but was postponed to 10/31/01. It was not performed on that date because of equipment failures or supply shortages at the facility. Exh. E, Grievance 11/3/01.

[8] Dr. Antonini's chart entry of 10/12/01 highlighted "weight loss" on the *first* page, which appeared to end at the bottom of the page. To see his differential diagnosis of throat or stomach cancer, a reviewing physician would have to flip back *two* pages, or would have to look beyond the chart to the physician's orders and the referral and testing forms. Exh. C, at 13-14.

been ordered by Dr. Antonini almost three weeks before, even though the referral form indicates that as of 11/1/01 CMS had not yet approved the ENT referral. Exh. D, at 14. She again missed the fact that the chest x-ray *she* had ordered six weeks earlier had not yet been scheduled, let alone performed. Exh. C, at 12. A reasonable jury could conclude that these were in part systemic failures, tied to the lack of functioning tickler system or insufficient staffing levels.

On 11/3/01 Mr. Broder filed another grievance because neither the ENT/GI visits nor the tests had taken place. He wrote, "I have lost an additional 10 pounds (approximate) and have continual excruciating pain." Exh. E, Grievance. The information in his 11/3/01 grievance was not entered into his medical file; he also noted that his earlier grievance (probably the one dated 8/31/01) and his letter to Dr. Pramstaller (of 9/23/01) still had not been answered. *Id.* Ms. Epp was the MDOC official who responded to the grievance at the Step II level.

On 11/13/06, Mr. Broder finally saw an ENT, who found lesions on both vocal cords. Exh. D, at 15. The ENT filled out a form for biopsy surgery at Foote Hospital to be done "within 2-3 weeks." Exh. D, at 16. On 11/16/01, Dr. Mathai reviewed lab results but she took no steps to ensure that the biopsy surgery was in fact scheduled within the 2-3 weeks, as ordered by the ENT. Exh. D, at 17; Exh. C, at 10-11.

To the contrary, although Dr. Mathai signed the ENT's request for biopsy on 11/14/01 (the day after he wrote it), and she approved his dictation on 11/20/01, Exh. D, at 15, she did not fax the form to CMS for approval until 11/26/01 – two weeks in to the 2-3 week period for the biopsy to be *performed*. Exh. D., at 16. In her 11/26 and 11/28/01 chart notes, she wrote only that Mr. Broder was "being evaluated for GI cancer" and that he will be undergoing an EGD. At this point, it was two weeks *beyond* the 30 days by which Dr. Antonini had expected test *results* (in the form of a confirmed diagnosis). She noted only that the ENT requests were "pending,"

and set Mr. Broder's next appointment for 30 days out. Exh. C, at 9. A reasonable jury could find that these processes – pursuant to which the forms went unfaxed for two weeks and the PCP did nothing to speed the scheduling of the urgent appointments and permitted their further delay – amount to deliberate indifference and were a proximate cause of the harm Mr. Broder suffered.[9]

Three days later, on 11/29/01, Dr. Mathai filled out an "Offsite Specialty 30 Day Follow-Up Form" for the diagnostic tests that had not yet taken place. She checked the box on the form that said it would be appropriate to await completion of the offsite procedures. Exh. D, at 21. By not scheduling an interim visit, she guaranteed that no one would look at the patient's file again for another 30 days. Mathai Dep., Exh. H at 81, 86; Norman Dep., Exh. O at 41. Dr. Mathai testified that Mr. Broder needed to be seen within 2-3 weeks of 11/13/01 and that she would not have filled out the form if she had known that the throat biopsy surgery was not going to be scheduled until "way out in January." Mathai Dep., Exh. H, at 90.

CMS did not approve the biopsy until 12/5/01 – beyond the 2-3 week deadline for test *results* – and did not schedule the surgery until 1/11/02. Exh D, at 22. A reasonable jury could conclude that a scheduling mechanism that allows a test to be scheduled almost six weeks beyond the deadline set by the ordering physician evidences a systemic failure that amounts to deliberate indifference to serious medical needs. Here, because Dr. Mathai had already filled out the 30-day extension form, and because she had not scheduled an interim follow-up visit to get the case back on her docket, she could not and did not know of the delay. Indeed, she did not see Mr. Broder again until 1/2/02. From 10/12/01 to 1/11/02, there is nothing in the medical record

[9] The defense theory to date has been that Dr. Mathai did nothing wrong and at all times was simply following the policies, procedures, and protocols in place. Accordingly, if a jury were to find that the delays amounted to a violation of Mr. Broder's Eighth Amendment rights, and if the same jury were to credit the defense account that the PCP was not at fault, then the jury could find the systemic failures to be a (or the) proximate cause of the harm he suffered.

to indicate that Dr. Mathai ever did anything with CMS or with the specialists to speed up the appointments or to get timely test results. Exh. C. A reasonable jury could conclude that the delay from 11/13/01 to 1/11/02 was caused by a systemic breakdown – or worse, that it was the *natural and predictable result* of the MDOC health care policies and practices in place at Parnall Correctional Facility in 2001-02.

On 12/6/01, Dr. Pramstaller answered Mr. Broder's letter of 9/23/01, about the delays in his diagnosis and treatment. Dr. Pramstaller wrote, "Further diagnostic studies have been considered and staff have taken appropriate steps in that regard…. [Health staff] are following your case closely." Exh. E, Letter 12/6/01. Dr. Pramstaller said that if he had known that tests to rule out cancer should have been completed weeks *before* his reply, he would have written a different letter. Exh. F, at 73. If the chief medical officer – in apparent response to a specific request on his part – cannot get an accurate picture of a patient's progress, then a reasonable jury could conclude that the *system* fell below the constitutional floor, in violation of the Eighth Amendment.

Dr. Mathai did not examine Mr. Broder in December and there are no notes in the chart showing she checked on the outstanding tests. Exh. C, at 9. On 12/12/01, a nurse interviewed Mr. Broder in answer to his 11/3/01 grievance. He told the nurse that his cancer tests had not yet been done (even though Dr. Antonini had wanted diagnostic results by 11/13/01 and even though the ENT had wanted the biopsy results by 12/4/05). Exh. E, 11/3/01 Grievance Response. Still nothing happened. Dr. Mathai did not see Mr. Broder again until 1/2/02, when she approved yet *another* 30-day delay form (Exh. D, 30-Day Form, at 24), despite noting that the EGD test still had not been scheduled. Exh. C, at 9. The throat biopsy surgery was then scheduled for 1/11/02.

To sum up, Dr. Mathai missed the differential diagnosis of throat cancer in August, causing a seven-week delay before Dr. Antonini saw Mr. Broder in October. Dr. Antonini ordered

the appropriate referrals and diagnostic tests on an urgent basis; he expected a confirmed diagnosis within 30 days – by 11/12/01. Despite the urgent requests, Dr. Mathai took no steps to speed the process, or to monitor it, and a reasonable jury could find that she was unaware for a time that Dr. Antonini had even ordered the tests. Exh. C. Next, when the ENT ordered a biopsy within 2-3 weeks (that is, by 12/3/01 at the outside), Dr. Mathai did not even fax the forms to CMS for two weeks, and then she signed a 30-day form that – combined with her failure to schedule a follow-up patient visit – guaranteed that the case would not come back to her attention until early January 2002. A reasonable jury could find that the policies and procedures in place at the time – for staffing, for access to medical care, for information entry, for monitoring of urgent medical needs, for the procurement of specialty care services – were cumulatively if not individually dysfunctional, and were a proximate cause of the delay in Mr. Broder's diagnosis and treatment.

On 1/11/02, Mr. Broder finally had the throat cancer biopsy surgery. Exh. D, at 25, 28-29 (pathology report), & 46 (post-dated operative report). On 1/22/02, the ENT reviewed the results with Mr. Broder and told him that he had cancer. Exh. D, at 30. Thus, although Dr. Mathai had enough information on 8/20/01 to test for throat cancer, it took 22 weeks to get a confirmed diagnosis. On 1/22/02, the ENT submitted an "urgent" referral stating, "Needs ASAP referral to radiation oncology at Foote [Hospital in Jackson] for [cancer of the larynx.]" Exh. D, at 31. The paperwork shows that the ENT did not expect to have any further contact with Mr. Broder until his treatment was concluded; the ENT asked that Mr. Broder return for a follow-up visit after completion of his radiation treatment. *Id.* As Mr. Broder put it, "He told me ... he'd see me in seven weeks when the ... radiation was done." Exh. G, at 122.

Despite a barrage of kites, Exh. E, Kites of 1/2801, 2/4/01, 2/25/01,[10] & 3/26/02, Mr. Broder's treatment did not *begin* for almost 2½ more months. Not until 1/30/01 – eight days after the ENT had requested the "urgent/ ASAP" radiation treatment – did Dr. Mathai review and sign the ENT's request form.[11] Exh. D, at 34. Dr. Mathai scheduled Mr. Broder for a follow-up appointment with her in three weeks. Exh. C, at 7.

Pursuant to the request, a radiation/oncology consultation was scheduled at Foote Hospital for 2/5/02. On 2/5/02, Mr. Broder saw a radiation oncologist (Dr. Hayman) at Foote who filled out a form for radiation therapy, and who requested a follow-up appointment in 1-2 weeks. Exh. D, at 42-44; Form 409, at 45. The doctor's expectation was that *treatment would begin* within the 1-2 weeks. Hayman Dep., Exh. K, at 15-16, 30.

From this point, Mr. Broder became "lost to follow-up." Exh. D, Patient History, at 86. On 2/8/02, Dr. Mathai reviewed the form request for radiation. Exh. D, at 45. CMS approved the form on 2/12/02. Exh. D, at 48. For unexplained reasons, no date was initially set for the radiation oncology appointment. Dr. Mathai did not follow up to make sure that the form was timely sent, or that it was timely processed, or that the treatment started within the deadline set by the radiation oncologist. No system was in place to ensure that the appointment occurred. (CMS/patient services later scheduled the radiation targeting for 3/12/02, and the start of radiation for 3/19/02 – way beyond the 1-2 week time-frame of the requesting doctor.) Exh. D, at 48. Dr. Mathai did not sign off on Dr. Hayman's dictation from 2/5/05 until 2/28/05 – long after the

---

[10] In preparing the Appendix, the kite dated 2/25/01 was inadvertently placed in the medical records, *see* Exh. D, at 51, rather than in Exh. E with the other grievances.

[11] The record reflects that Dr. Mathai called patient services to ask them to schedule the radiation planning appointment for "this week." The phone call is the only time Mr. Broder's medical file reflects Dr. Mathai taking any direct action to expedite his treatment. Exh. C, at 7. It also shows that when a PCP took direct action, a PCP could get results: the appointment was scheduled that week.

1-2-week start-time for the radiation simulation appointment had passed.

On 2/13/06, the Foote Hospital oncologists submitted a form for a CT scan, to stage the cancer and to do the radiation targeting. Exh. D, at 49. The scan was apparently never approved by CMS. On 2/22/02, Dr. Mathai saw Mr. Broder. She noted in the progress notes that she did not have his chart. Exh. C, at 6.[12] At that point she took no action to confirm that Mr. Broder's targeting or treatment appointments had been scheduled or that the necessary forms had been approved. Dr. Mathai told Mr. Broder to return in three weeks and instructed him to file a kite if his treatment did not begin on 2/25/02. On 2/25 he submitted a kite. The nurse who reviewed the kite replied, "Radiation to start next week." Exh. D, Kite 2/25/01, at 51. The radiation was not scheduled to start the next week; it did not start for more than a month. As one doctor put it, "He became rather lost to follow-up after 2/5/02 when he was seen in Radiation Therapy and it was recommended that he start treatment." Exh. D, at 86. Another wrote, "Transportation difficulties caused him to miss his radiation follow-up, ENT follow-up, and his scheduled CAT scan." Exh. D, at 90.

Dr. Mathai went on maternity leave on 3/8/02. There is no indication that she took any steps to make sure that Mr. Broder's "urgent" treatment either had begun or was about to begin before she left. To that point, by her own admission, she had suspected that he had cancer for nearly seven months. It had taken five months to get a diagnosis, and in the 6½ weeks since Mr. Broder still had not completed the *pre*-treatment protocols. Exh. D, at 55.

On 3/8/02, a Foote radiation oncologist again requested a CT scan, marked "Urgent."

---

[12] The defendants imply that it was Mr. Broder's fault that his chart was "out for FOIA" copying in February 2002. Defendants' Brief, at 8. By that date prisoners were barred from using the state Freedom of Information Act, but a request had been made on his behalf. What is apparent is that there was no policy in place to make sure either: (1) that a medical file was not sent out at a critical time in the management of a patient's care; or (2) that a second copy of the essential information was available for emergencies.

Exh. D, Form 407 (Clark), at 55. This was the same test that Dr. Tsien had requested on 2/13, marked "ASAP" on the form, yet it had never been authorized. On 3/12/02, Mr. Broder went to Foote for his radiation simulation/treatment planning. At that point, it appears that CMS still had not approved the requests for a CT scan, but the Foote doctors simply ignored the lack of authorization and performed the scan anyway. (The CT scan request was approved retroactively by CMS the next day. Exh. D, Form 409, at 64; Exh. D, Simulation Notes, at 55.) The CT scan showed that Mr. Broder's cancer had spread to the epiglottis and was probably now Stage III. Exh. D, Scan Results, at 61-62. On 3/18/02, the Foote doctors requested an MRI – marked "URGENT-ASAP Please" and "STAT" – to determine more precisely the extent of the cancer and to get better pictures for the radiation targeting. Exh. D, Form 409, at 67-68. On 3/21/02, Mr. Broder's new primary care physician signed off the urgent MRI request, filled out the corresponding Form 407, and faxed them to CMS. Exh. D, Form 407, at 69. CMS approved it and the appointment was set for 3/27/02. Exh. D, at 71.

From 3/25/02 to 4/1/02, the Foote doctors requested several more authorizations for service. Exh. D, at 74-76, 79-80. The chemotherapist was concerned that Mr. Broder's throat was closing to the point where he could not breathe. Exh. D, at 77.[13] The MRI, done on 3/27/02, confirmed Stage III cancer. Exh. D, MRI Results, at 81-82. Stage III cancer requires chemotherapy as well as radiation. One oncologist wrote, "I am somewhat concerned about ... the duration of this work-up in view of the natural history of the disease…." Exh. D, at 83. Dr. Tsien noted that "numerous attempts were made to expedite his CT treatment planning scan." Exh. D, Inter-

[13] The transcript reads, "I am not concerned about his airway," but the chemotherapist testified: "I think that's a typographical error. I was – it should be, I am now concerned about his airway. I did take steps to contact the ear, nose and throat surgeon to ... verify that the airway was intact." Axelson Deposition, at 16 (not attached as an exhibit).

val Note, at 84. To sum up, even when all the players were aware that Mr. Broder had fallen through the cracks and his treatment had been inexplicably delayed, and even with Dr. Mathai out of the picture, it still took from 3/8/02 to 4/2/02 *for his treatment to actually begin*. A reasonable jury could find that the system of filling out forms for specialty care, and then getting them approved, and then having a scheduling unit arrange for tests and appointments, was so fraught with delays and failures, and was so consistently late at every stage, that the system itself was a proximate cause of the failure of medical care in this case. Only by blind luck did Mr. Broder's cancer not progress to the point where it cost him his larynx (or his life).

On April 2, 2002, Mr. Broder was admitted to Foote Hospital for chemotherapy and radiation treatment. Due to the need for chemotherapy, Mr. Broder was surgically fitted with a PEG tube to his stomach, to allow direct nutrition while bypassing the throat. Exh. D, at 85. The PEG tube site later became infected. Exh. D, at 88. Beginning April 2-3, 2002, Mr. Broder received seven weeks of radiation, and three rounds of chemotherapy in April, May, and June 2002.

Because of the delays, Mr. Broder suffered months of unnecessary pain and anxiety. His experts say his cancer went from Stage I to Stage III, requiring more invasive treatment. Exhs. 1 & 2; Exh. N, at 71-73. As a result, he suffered the effects of the treatment itself, as well as permanent dry-mouth, injury to his larynx, chronic hoarseness and weak voice, intermittent severe throat pain, dental problems related to his reduced salivation, and a much higher risk of death if his cancer recurs. Exhs. 1 & 2; Exh. N at 85-88; Exh. G, at 129, 136-41. At present he appears to be free of cancer.

B. Applying Eighth Amendment Law to the Facts

The defense argues that Dr. Mathai did nothing wrong because at all times she followed the MDOC/CMS policies and procedures for monitoring serious disease and for the provision of

urgent care. Where – following the established protocols – a PCP cannot get her cancer patient diagnosed for five months, and cannot get him treated for almost eight months, then (under the defendants' logic) a reasonable jury could conclude that the fault must lie with the system itself.

As noted in Mr. Broder's brief in response to the CMS defendants' motion, the law in cases like this one is straightforward. There can be no doubt that the failure to timely diagnose and treat cancer, causing months of pain as well as permanent harm, meets the objective test of a serous medical need. Exh. N, at 85-88; Exh. G, at 129, 136-41. As to hands-on prison officials or medical staff who know of the plaintiff's condition and know that he requires medical attention, if they fail to take steps to ensure timely diagnosis and treatment, the Eighth Amendment standard is met. *See e.g., Blackmore v. Kalamazoo County*, 390 F.3d 890, 896 (6th Cir. 2004); *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).

An Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall him; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm. *Terrance v. Northville Regional Psychiatric Hospital,* 286 F.3d 834 (6th Cir. 2002). A reasonable jury can conclude that prison officials knew of a substantial risk from the very fact that the risk was obvious. *Id.* at 843. It is hard to imagine a patient with a more obvious risk than cancer that was suspected as early as 8/20/01 and who could and should have been diagnosed at once, but who was not diagnosed for five months and who was not treated for almost eight months. Where the need for medical care is obvious, care which is so cursory as to amount to no treatment at all can amount to deliberate indifference. *Id.* at 843-44, *citing Mandel v. Doe*, 888 F.2d 783, 789 (11th Cir. 1989).

As to higher prison officials like chief medical officer Pramstaller and regional health care administrator Epp, the legal standard is somewhat different. Contrary to what the MDOC defendants argue, *see* Defendants' Brief, at 11-20, senior prison officials can be held liable for damages in their individual capacity. The cases in support of this proposition are legion,[14] and they clearly set out the applicable legal standard.

To hold senior prison officials liable in their individual capacity, the plaintiff must show *either* that the senior officials participated directly in the unconstitutional act – which is not the claim here – *or* that there is a causal connection between the actions of the supervisory officials and the alleged constitutional deprivation. A causal connection can be established in several ways, including (1) a history of widespread problems that put the supervisory officials on notice of the need to correct the alleged deprivation, and they failed to do so, or (2) the supervisory officials' custom or policy 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).[15]

The Second Circuit applied much the same standard in *Brock v. Wright*, 315 F.3d 158

---

[14] To eliminate distinctions, Mr. Broder will only cite cases involving *state* correctional facilities and *state* prison officials, as opposed to federal, county, city, or private facilities and officials.

[15] Much the same standard applies in failure-to-protect cases. *See e.g., Valdez v. Crosby,* 450 F.3d 1231, 1237-38 (11th Cir. 2006) (warden denied summary judgment and qualified immunity in the context of a beating by rogue guards, where there was evidence of widespread physical abuse and warden failed to take steps to stop it; whether warden had established customs or policies that resulted in deliberate indifference was a factual question for the jury in light of the evidence presented by the plaintiff in opposition to summary judgment); *Smith v. Brenoettsy*, 158 F.3d 908, 912-13 (5th Cir. 1998) (affirming denial of summary judgment in light of factual dispute as to warden's knowledge of substantial risk and reasonableness of warden's response, where plaintiff, who was stabbed by a prison guard, had sent letters to warden complaining of verbal abuse and threats by guard, and warden responded that sheer volume of complaints made investigation of every complaint unreasonable).

(2nd Cir. 2003). There the prisoner plaintiff had a painful scar growth on his cheek. The pain was bad enough that he could not brush his teeth on one side, causing dental problems. Senior health officials denied treatment because the condition was "cosmetic." The court found the condition to be sufficiently serious as an objective matter to state an Eighth Amendment claim. *Id.,* at 163-64. The court then turned to the subjective prong of the test. As to the chief medical officer, the court found that a reasonable jury could conclude that the prison medical *policy* not to treat keloid scars, as applied to the plaintiff, violated his Eighth Amendment rights. The court said the chief medical officer could be liable where he "created a policy or custom under which unconstitutional practices occurred or [where he] *allowed the continuance of such a policy or custom*." *Id.,* at 165-66 (*emphasis added*). The court added that the failure to try to prevent the scar growth in the first place (again pursuant to policy) presented a fact issue for the jury as well. *Id.*, at 167. *See also Burke v. North Dakota Dept. of Corrections*, 294 F.3d 1043 (8th Cir. 2002) (medical director could be liable for failure to treat prisoner with Hepatitis C).

Moreover, although Dr. Pramstaller's and Ms. Epp's actual knowledge of Mr. Broder's condition should be irrelevant here in light of the overwhelming evidence of a systemic failure of specialty/urgent care, courts have found that even very limited personal knowledge can result in individual liability. For example, in *Richardson v. Goord*, 347 F.3d 431 (2nd Cir. 2006), the plaintiff included the New York State Corrections Commissioner as a named defendant. The appellate court described supervisory liability under § 1983 as follows:

> Supervisor liability under § 1983 "can be shown in one or more of the following ways: (1) actual direct participation in the constitutional violation, (2) failure to remedy a wrong after being informed through a report or appeal, (3) creation of a policy or custom that sanctioned conduct amounting to a constitutional violation, or allowing such a policy or custom to continue, (4) grossly negligent supervision of subordinates who committed a violation, or (5) failure to act on information indicating that unconstitutional acts were occurring." [*Citations omitted.*]

> Richardson testified at his deposition that he wrote Goord a letter complaining that [his] dosage was being withheld and that he was suffering great pain at night. The present record is sketchy. Richardson testified that he did not have a copy of the letter because it was missing from his cell. It is unclear what Richardson's letter said, when it was written, and whether any prison officials can locate a copy. However, the evidence may create an issue of fact as to whether Goord was deliberately indifferent to Richardson's medical needs. Accordingly, we vacate and remand to the district court for further fact-finding with respect to Goord's knowledge of Richardson's condition.

Richardson, *supra*, at 435. In *Richardson*, the DOC commissioner was not being sued based on a policy or custom that blocked treatment, but because he arguably had personal knowledge (albeit very limited) of the problem and failed to take steps to address it. Accordingly, this Court should deny defendant Pramstaller's and defendant Epp's motion for summary judgment not only because of the evidence of widespread problems in the delivery of specialty/urgent care, but also because both defendants had personal knowledge of Mr. Broder's case and did nothing.[16]

But Mr. Broder's core claim here is that the MDOC health care *system*, under the policies and procedures authorized or approved or tolerated by the MDOC defendants, caused months of unnecessary pain and suffering as well as permanent harm to Mr. Broder. On this issue, even the defense experts agree that the delays in each phase of Mr. Broder's case were outside of acceptable bounds. As to Dr. Mathai's 8/20/01 suspicions of cancer, Dr. Norman testified:

> Q. My question is, assuming [Dr. Mathai] was concerned that [Mr. Broder] might have cancer. And at this point she identifies in her mind two kinds of cancer that could cause the symptoms that have been reported, how soon should she have an answer as to whether or the [Mr. Broder] has cancer to be within the standard of care?

---

[16] Under *Richardson*, Dr. Pramstaller's liability is based on his personal knowledge of Mr. Broder's case *via* the letter and response described above. Ms. Epp's liability would be based not – as the defendants' suggest – on the bare fact that she responded to Mr. Broder's grievances, but rather on the fact that the *content* of those grievances put her on notice of the late diagnosis and treatment of his cancer, and that (as regional health administrator) she was in a position to do something about it. The Court should note that Ms. Epp reviewed Mr. Broder's grievance of 10/11/01 as well as his "policy-and-practice" grievance of 7/12/02. She also apparently requested a review of his case in March 2001, when the delays were being questioned by the Foote Hospital doctors. *See* Exh. 2, Barrett Dep., at 146-57.

A. I would say certainly within a matter of days you would expect, just because of the nature of the procedure. It's not that complicated to do.

Exh. O, at 37-38. Dr. Pramstaller said:

Q. Taking her at her word, and assuming that she ... did the ... chest x-ray because she suspected that [Mr. Broder] might have cancer, ... how long is an appropriate amount of time in your view for this patient to have a result back on the chest x-ray, so that we can rule in or rule out lung cancer?
A. Two or three weeks.

As to the tests that Dr. Antonini ordered on 10/12/01 (expecting a confirmed diagnosis within 30 days), and that became Dr. Mathai's duty to follow up on as the PCP, defense expert Norman agreed that the results should have been available "within weeks." Exh. O, at 50-51.

Q. When you say weeks instead of months, does that mean ... four weeks or less, so that we're using weeks instead of months?
A. I would say four to six weeks.

Id., at 52. Dr. Pramstaller concurred:

Q. I'm not asking about having someone look at him, I'm asking how long should you wait from October 12th to know whether he has cancer or not? What seems to you like the outside margin?
At this point you've agreed [from Mr. Broder's letter to you of 9/23/01], and Antonini has agreed in a much more vehement way two-and-a-half weeks later, laryngeal cancer is a real possibility here. So by when do we need to know whether he has it or not?
A. I would say that the longest I would be comfortable with would be eight weeks.

Exh. F, at 53. From that point it was 13-14 weeks (mid-January) before there was a diagnosis.

Regarding the ENT's request on 11/13/01 for biopsy surgery within 2-3 weeks, we know that surgery did not occur for two months. Dr. Mathai signed a form that allowed the case not to come back to her attention for more than 30 days. Although Dr. Pramstaller testified that he "would have questions" whether or not it was appropriate for her to sign the form, or to sign yet another 30-day form on 1/2/02 (Exh. F, at 69), the form was one that the MDOC and CMS had approved for use in the prisons in precisely this situation. It allowed the PCP to put the case over

for 30 days, knowing that if there were a problem – then absent a "next-visit" tickler scheduled in the interim – the problem would not discovered for at least a month, at which point the process of scheduling the patient would have to begin anew. If this case shows anything, it is that the delays at every stage were completely predictable and, indeed, were effectively *built in to the process*. As one of the plaintiff's experts put it, "[T]he work-up was proceeding at a snail's pace." Everything was "way too slow." Exh. M, at 54, 18.

Once Mr. Broder's cancer was diagnosed, Dr. Hayman said the outside window from diagnosis to treatment should be 4-6 weeks. Exh. K, at 40. Dr. Pramstaller and Dr. Tsien agreed. Exh. F, at 74-76, Exh. L, at 48-49. The plaintiff's experts agree. Exhs. 1 & 2. Yet Mr. Broder went from mid-January to April 2 before his treatment began, and then it only happened because of the clamoring of the doctors at Foote Hospital. The startling thing is that even when the PCP physician knew that the *diagnosis* had taken months longer than each requesting doctor had wanted, there was apparently still nothing she could do – *within the policies and procedures established* – to speed up the initiation of treatment.

The claim against defendants Pramstaller and Epp is that the procedures at Parnall Correctional Facility in 2001-02 were constitutionally deficient. The record shows that at every phase of the case – over and over again – it was impossible to get urgent care on time. The system required that any outside specialty care – both consultations and tests – had to be procured by (1) correctly filling out the right form, (2) having it sent (typically) to the PCP for her approval, (3) forwarding it to CMS for its approval, (4) having it go to a scheduling unit to arrange for the appointment to be made, and (5) then making sure that the appointment was actually scheduled and kept. *See e.g.,* Exh. H, at 72-76. Any follow-up care required that the same steps be done again. Exh. Q. And in 2001-02 – according to Dr. Mathai – the physicians and the schedulers

never consulted with each other. Exh. H., at 79.

What the record in this case amply demonstrates is that forms were not filled out, or if filled out were not timely approved by the PCP, or if approved were not timely forwarded to CMS, or if forwarded were not timely approved by CMS. If the forms *were* timely approved, the appointments were not timely scheduled (within the limits set by the requesting doctors), or the actual appointments were subject to cancellation due to transportation problems, faulty equipment, *etc*. Over and over again the record shows that the prison medical system *could not provide urgent care* within the time-frames of the requesting doctors. To get timely urgent care, the doctors had to take extra measures (like personally calling the scheduling office), or had to violate protocol (like doing a test without approval and getting the approval after the fact). Exh. C, at 7. Otherwise, nothing happened on time – even with a cancer patient.

When nothing happened, there were no procedures in place to catch and/or to correct the problem. The only "tickler" system was to re-schedule the patient for a clinic visit in 30-60 days. That meant that the problem typically would not come to the attention of the PCP until the time for results had long-since passed. It also required (1) that the follow-up appointment not be canceled; (2) that the same doctor see the patient; (3) that she have recorded in the file what needed to be done, so that she (or a replacement doctor) could discover the delay or the lapse; (4) that the PCP actually *review the file* at the next appointment in sufficient detail to catch the error, and (5) having noticed the lapse, that the PCP do something about it other than approving the delay or awaiting some future (still unknown) re-scheduling date.

Dr. Hutchinson conceded in his deposition that – absent some other intervention – under the "next visit" system a PCP would not know until the next visit if a glitch occurred. Exh. I, at 48-49.

Q. In a situation like this where the scheduled appointment is five to six weeks beyond the date that the specialist has requested, what check or system is in place at the facility to catch that?

A. I don't know what was in place at the facility to monitor that, to question that other than the scheduling of the patient with the primary care provider every thirty days while awaiting the delivery of the specialty service.

* * * * * *

Q. If she doesn't come over and he doesn't see her for thirty more days, isn't it guaranteed that if there was a problem that she is not going to know about it until we're now roughly four weeks passed the deadline the expert had set?

A. Well, that's the way the system is set up, for every thirty day visits. If she had elected to see him sooner than that she would have had that ability. But the system is set up to bring the patient back every thirty days. *It's a one size fits all thirty days. It's not varying by the nature of the problem.*

Huchinson Dep., Exh. I, at 70, 76-77. In other words, if you need urgent care, you aren't going to get it, because the system is not designed to vary based on the nature of the problem. Dr. Hutchinson said that he "would not engineer" such a system deliberately to cause delay, *id.* at 80, but that is exactly what he did. The MDOC defendants authorized or approved or tolerated the system with full knowledge of its predictable results. Exh. P, *Hadix* Order (2002).

The defendants try to lay the blame for the delays at the feet of the consulting specialists, but the consistent message from the specialists is that they were powerless to set appointments. They had to submit the appropriate form and rely on the prison system to take it from there. As Dr. Tsien said, "I can't bring [the prisoner] to my office." Exh. L, at 19-20. She made it sound like her office noticed that Mr. Broder was late (in February 2002) and immediately began calling the prison to try to get him scheduled, with no result. *Id.*, at 21-23. She was not aware of anyone from the prison side pressing to get the appointment made – she said she had never heard of Dr. Mathai and had never spoken to any prison doctor about scheduling. *Id*., at 28-30. When asked how the process worked, she answered, "I wish I knew. To this day I don't know." *Id*., at 30. A reasonable jury could conclude that in 2001-02 the system for specialty care scheduling was dys-

functional, and that the MDOC defendants knew it and did nothing. That is enough for liability under the Eighth Amendment. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

The other systemic problem was that none of the written information from the patient was recorded in a way to be of use to the PCP. It is undisputed that none of the contents of Mr. Broder's health care kites, his letters directly to the health care providers, his grievances, or his letter to Dr. Pramstaller, ever made it into his medical file. The letters to the health care providers and the kites to the nurses are especially egregious because the prisoner-patient has no other way to communicate. This, too, was a systemic problem, that was the responsibility of chief medical officer Pramstaller and regional health administrator Epp to change or to cure.

Q. When the information in that kite relates to the prisoner's medical condition, would you expect the information in the kite to make it into the medical record?
A. Yes.

* * * * *

Q. And if the information that the patient has written into the request doesn't make it into the medical record and it's important information, in your view, does that indicate some kind of breakdown in the system? [Objections omitted.]
A. It could indicate a breakdown in the system.

Exh. O, Defense Expert Norman Deposition, at 44-45. *No information* from Mr. Broder ever found its way into his file, despite a steady stream of detailed kites, letters, and grievances all saying the same thing. A reasonable jury could find that the system of accessing health care and getting critical diagnostic information to the health care providers violated Mr.Broder's Eighth Amendment rights.

As to the MDOC defendants' individual responsibility, Dr. Pramstaller testified that as of July 2001, he was the acting chief medical officer for the MDOC. Exh. F, at 3.[17] As to regional

[17] At least until November 2001 the position of administrator of the MDOC Bureau of Health Care Services was vacant. In any event, the administrator is not a physician – making Dr. Pramstaller the senior MDOC physician, as he acknowledged. Exh. F., at 8-9.

administrator Epp, Dr. Pramstaller testified:

Q. ...if the processes that were in place in her region turned out to inhibit the provision of quality care or timely care, would that ultimately be her responsibility?
A. I believe so, yeah.

Exh. 1. Accordingly, a reasonable jury could find that chief medical officer Pramstaller and regional health care administrator Epp were responsible for any systemic failures that were a proximate cause of the harm suffered by Mr. Broder, in violation of the Eighth Amendment.

C. The *Hadix* Evidence

The delays in Mr. Broder's diagnosis and treatment were not aberrations, but were part of a systemic failure of care with which the MDOC defendants were all too well-acquainted. At all relevant times Mr. Broder was housed at the Parnell Correctional Facility in Jackson. Parnall was one of the facilities covered by the consent judgment in the long-running *Hadix* litigation.[18] Indeed, at the very time that Mr. Broder's cancer remained undiagnosed and untreated, the *Hadix* court was monitoring the care provided to patients with serious diseases and urgent medical needs at the Parnall facility. Exh. P, Findings of Fact and Conclusions of Law, (2002), ¶¶ 17, 31, 33. As to the precise issues presented by this case – timeliness of diagnosis and treatment, system-wide failures of care and/or supervision, pervasive scheduling delays for urgent care, systematic failure to coordinate and monitor, *etc*. – the *Hadix* court made the following determinations after a hearing in May 2002, which itself was based on monitoring which occurred in mid-to-late 2001 (the very time when Mr. Broder's cancer was going undiagnosed and untreated):[19]

---

[18] For a description of that litigation, *see* the *Hadix* court's recent Findings of Fact and Conclusions of Law (Order of 12/7/06), excerpted as Exh. Q, at 1-5. Upon information and belief, Mr. Broder is a class member in the *Hadix* case.

[19] For each of the findings and conclusions, the *Hadix* court recited a long series of factual examples in random cases unearthed by the monitor. The *Hadix* court based its findings on those recitations. Exh. P, Excerpts.

217. **[Prisoners with Urgent and Emergent Symptoms]** Based on the number and severity of incidents, their pervasiveness among the health care outcomes examined, and their serious consequences to patients in need of serious medical treatment, the Court finds that the system of access to health care did not provide reliable and timely access to care for prisoners with urgent or emergent symptoms. ...The Court finds that the existing system of access continues to violate ... the Eighth Amendment....

324. **[Responses to Kites]** Based on these pervasive and serious failures to timely address serious medical needs, the Court finds that the implementation of the access to health care system did not provide reliable access to care for prisoners with urgent or emergent symptoms. ...The Court finds that the existing system of access continues to violate ... the Eighth Amendment....

356. **[Harm from Failures of the Health Care Access System]** The failures of the health care access system have caused prisoners serious harm and inflicted unnecessary pain, suffering and loss of function.

370. In [the sample cases] and many other cases the failure to provide timely treatment created a serious and obvious risk of harm to the prisoner.

371. The Court finds that the existing system of access and its implementation continues to violate ... the Eighth Amendment....

473. **[Chronic Disease: Harm to Patients from Medication Interruption]** Based on the pervasiveness of [sample] incidents involving serious and preventable health consequences and unnecessary pain, the Court finds that the medical treatment for prisoners with chronic diseases continues to violate ... the Eighth Amendment....

475. **[Clinical Practice: General Issues]** According to Defendants' own internal audit, during the period from October 2001 through January 2002, the performance ratings of the mid-level health staff (nurse practitioners and physicians' assistants) ranged from a low of forty percent to a high of sixty percent. As a result of this finding, Dr. Pramstaller recommended that CMS be notified that it was in violation of its contract requirements to provide clinical supervision to the mid-level providers.

476. It is Dr. Pramstaller's opinion that the results of the audit indicate "very poor" performance by the physician providers in auditing mid-level staff.

618. **[Physician Supervision of Health Care: Ensuring Appropriate Levels of Clinical Performance]** The medical staff in place do not reliably perform their duties with an acceptable level of skill and expertise.

701. **[Referrals for Specialty Services]** MDOC met with CMS and an agreement was reached that if a 10-day requirement exists (*i.e.,* urgent care), the paperwork turnaround must be accomplished in a day.

702. MDOC and CMS recognize that there are some specialty areas as to which appointments are scarce both in the free world and in corrections. [Discussing such scarcity-based delays] ... In those cases, *it becomes the primary care physician's responsibility for determining whether the appointment scheduling is acceptable.* (Emphasis added.)

The *Hadix* court's findings of fact and conclusions of law are powerful evidence in support of Mr. Broder's claim that the delays in his case were proximately caused by flaws in the health care system. The court was looking at exactly the same policies, procedures, and systems for treating prisoners with serious disease and urgent medical needs that are at issue here. The pattern of delay, failure to monitor, and failure to supervise Mr. Broder's case is consistent with the pattern revealed in the study of similar cases, conducted at the same time and place, and involving hundreds of similar prisoner-patients. Exh. P. Dr. Hutchinson admits that the system in place then was worse than today (Exh. I, at 63), yet even today, after four more years of work, and after some significant improvements, as to these specific issues, the *Hadix* court still finds the *system* to be constitutionally deficient. Exh. Q.

The *Hadix* case provides the strongest possible evidence because it shows that Mr. Broder's late diagnosis and treatment were not isolated or aberrational events, and that the MDOC defendants had detailed knowledge of the system's shortcomings. One of the chief targets of the *Hadix* court's ire has been the policies and procedures governing *urgent care* in cases like Mr. Broder's. As the *Hadix* court aptly said in its recent order (describing the *improved* version of the same system that was in place in 2002):

> Both the persuasive testimonies [of the expert monitors] demonstrate clearly and beyond peradventure that *the specialty referral process is "profoundly deficient."* [Record citation omitted.] *Such care is routinely delayed beyond the time medically necessary. Furthermore, the delays tend to topple one upon the other for patients with regular needs for specialty service (e.g., cancer patients). Such delays cause unnecessary death, illness and extreme suffering.* In light of such record, it is clear that injunctive relief is necessary to prevent further irreparable harm to class members.

Exh. Q, ¶ 110, (*emphasis added.*)

In sum, where another federal district court has already concluded that the policies, procedures, and health care systems in place at Parnall in 2001-02 violated the Eighth Amendment, this Court cannot grant summary judgment on the grounds that there is no genuine issue of material fact that they did not. Nor does the plaintiff need separate expert testimony to establish by a preponderance of the evidence that the policies and procedures were a proximate cause of the harm he suffered. As noted in detail in Part I (A) above, experts on both sides have testified that the diagnosis and treatment of Mr. Broder's cancer fell outside acceptable time limits at each phase of his medical work-up, and even the defense expert on prison medical care conceded that some of the failures – like the failure to get critical information to the PCP – can accurately be called "systemic." On the evidence submitted on summary judgment, taking all the facts in the light most favorable to the plaintiff, a reasonable jury could find that defendants Pramstaller and Epp violated Mr. Broder's Eighth Amendment rights because the policies and procedures in place at Parnall in 2001-02 were a proximate cause of his injuries and amounted to deliberate indifference to his serious medical needs.

II. THE EXHAUSTION ISSUES

The MDOC defendants argue that Mr. Broder failed to exhaust his administrative remedies under the PLRA. *See* MDOC Defendants' Brief, at 21-28.

A. The 2004 Motion to Dismiss

First, the Court has already decided this issue. In response to the CMS defendants' 2004 motion to dismiss, as well as *sua sponte* pursuant 28 U.S.C. § 1915A, the U.S. Magistrate Judge issued a report and recommendation (dated 8/9/04) that was – as to this argument – adopted by the Court in a short opinion and order (dated 9/22/04). That is to say, the R&R explicitly found

that the four grievances attached to the complaint were fully exhausted. *See* R&R, at 8-9. The Magistrate Judge found that in each case the plaintiff timely appealed his grievance to Step III, and that he did not file his lawsuit until long after the period for a Step III response by the Department was due. R&R, at 19. Contrary to what the MDOC defendants now assert, the Court has already found that all four grievances were fully exhausted.[20]

B. The "Policy and Practice" Grievance

As to the MDOC defendants bringing this motion, Mr. Broder filed a grievance on July 12, 2002. The grievance stated as follows:

> Medical kites were submitted and conversations held with medical staff at different visits.
>
> Having had a medical complaint lodged in approximately March of 2001 and left in an untreated state until April of 2002, where cancer was detected in January of 2002, has caused the necessity of filing this grievance. I was hospitalized for the majority of April, and portions of May and June, due to the delays in diagnosis and treatment.
>
> I am filing this grievance to complain about the delays in diagnosis and treatment of my cancer, which caused months of unnecessary pain and medical complications. I want to make sure this never happens again and want compensation for the harm I have suffered. This grievance is against the following doctors and staff (see attached list), and any other treating personnel, supervising personnel, and any and all other individuals or organizations involved in the diagnosis, treatment, or referral of my condition. Policy 03.04.100 indicates that "The Department shall provide ... a continuum of health care services that is accessible, timely, and provided in a humane ... manner," and pursuant to policy, Grievant's condition was either "urgent" or "emergent."

Mr. Broder attached to the grievance a list of 37 names pulled from his medical records, including Dr. Pramstaller and Jan Epp, and adding for good measure, "Any and all CMS personnel" and "Any and all MDOC personnel." *See* Complaint, Exh. 1, Grievances; *and* Plaintiff's Brief in

---

[20] The Court adopted the R&R in all respects but one. Judge Rosen found – as to the corporate entity CMS, Inc. – that it had not been named *in its corporate capacity* in the relevant grievance, and therefore it should be dismissed as a party-defendant. *See* Opinion and Order, at 2-4. The omission by the plaintiff was of no consequence, because the Court *also* found that suit against CMS was barred by the Eleventh Amendment. *Id.,* at 5. The Court then permitted the addition of CMS's state medical director, Dr. Craig Hutchinson, in place of the dismissed corporate defendant. *See* Order (dated 10/30/04).

Opposition to Motion to Dismiss, Exh. 1 (List). It is hard to imagine a more clearly stated or more thorough "policy and practice" grievance. The MDOC answered the grievance on the merits, and Mr. Broder timely appealed it through Step III of the grievance process.[21]

C. The *Woodford* Issue

The MDOC defendants next argue that dismissal is required under *Woodford v. Ngo*, 548 U.S. ___, 126 S. Ct. 2378 (2006). *Woodford* resolved a circuit split as to whether late-filed grievances could still fulfill the PLRA's exhaustion requirement. The Court held that they could not, in effect applying a "procedural default" rule. *Id.,* at 2387. That is to say, if a grievance is filed late, *and is rejected by the prison authorities on that basis*, the prisoner cannot appeal the tardy grievance to the final administrative step, and then file suit in federal court, as if he had filed a timely grievance in the first place. The Court said that to permit such a procedure would eliminate any incentive to file a timely grievance at the start, and to have the merits of the grievance addressed at the level of the prison grievance process, *before* permitting the far more costly avenue of federal court litigation. *Id.,* at 2384-88. The *Woodford* decision overruled *Thomas v. Woolum*, 337 F.3d 720, 723 (6th Cir. 2003), which had gone the other way on this issue. *See Woodford, supra,* at 2384.

The problem for the MDOC defendants here, of course, is that all four of Mr. Broder's grievances *were* answered on the merits, at each Step (I, II, or III) that an answer was given by the MDOC. None of the grievances was rejected as untimely. *See* Complaint, Exh. 1, Griev-

[21] The MDOC defendants are unclear about the alleged exhaustion defect. In the first part of their brief, *see* Defendants' Brief, at 10, they state that Mr. Broder never named any of the MDOC defendants in any of his grievances. Later on, however, *id*. at 24, they concede that Pramstaller and Epp were named in the July 12, 2002, grievance.

ances and Denials Pursuant 42 U.S.C. § 1997E(A).[22] In this situation, it simply does not matter whether *Woodford* is applied retroactively or not, because all four grievances were accepted as timely by the MDOC, and the prison authorities addressed the claims of each, and duly denied each grievance on the merits. *Woodford* itself suggests that in this situation exhaustion has been shown and that the plaintiff's case can and should go forward. *Id.*, at 2384-88 (noting that in *Woodford* the plaintiff's grievance was denied as untimely, and that prison authorities did not exercise their discretion to address its merits despite being untimely). *Id.,* at 2391-92.

Post-*Woodford* courts have agreed. For example, in *Jones v. Steward*, 457 F. Supp. 2d 1131 (D. Nev. 2006), the court said:

> The question raised by this motion is whether administrative remedies are properly exhausted when an inmate's untimely grievance is nonetheless addressed by the prison on its merits.
>
> The Supreme Court defines proper exhaustion as "using all steps that the agency holds out, and doing so properly (so that the agency addresses the issues on the merits)." 126 S.Ct. at 2385 [*citation omitted*]. ... We read Justice Alito's majority opinion in *Woodford* as setting forth two tests for "proper exhaustion." The "merits test" is satisfied when a plaintiff's grievance is fully addressed on the merits by the administrative agency and appealed through all the agency's levels. The "compliance test" is satisfied when a plaintiff complies with all "critical procedural rules," including agency deadlines. A finding that a plaintiff has met either test is sufficient for finding "proper exhaustion." Defendants must show that Plaintiff failed to meet both the merits and compliance tests to succeed in a motion to dismiss for failure to exhaust administrative remedies.

Jones, supra, at 1134. The *Jones* court reviewed *Woodford* with care – both as to its text and the policies underlying the decision – and concluded that:

> The majority opinion in *Woodford* indicates that the central goal served by requiring proper exhaustion under the PLRA is preventing prisoners from bypassing the administrative

[22] For the record, Mr. Broder does not agree that his grievances were untimely. In each case he filed his grievance soon after the event that he was complaining about. As to his "policy and practice" grievance, he filed it upon completion of his treatment, as soon as he was back on his feet. That grievance did not challenge a specific event, but rather the prison health care *system* that cumulatively caused the late diagnosis and treatment of his cancer. *See* Complaint, Grievance of July 12, 2002.

> grievance process. ... In *Woodford*, ... the inmate complainant failed to meet both the merits and compliance tests. [He] failed to meet the merits test because the California prison in that case never addressed his grievance on its merits. [*Citation omitted.*] His administrative appeal only dealt with procedural issues (whether a grievance regarding a continuing issue can be untimely), not the merits of his grievance. *Id.* at 2403 (Stevens, J., dissenting). Also, [he] failed to meet the compliance test by violating a critical procedural rule. He filed his grievance over five months after the deadline had passed. *Id.* at 2383-84. Defendants ask us to extend this ruling to dismiss the claim of a plaintiff who has only failed to meet one test. Reading *Woodford* in light of the policy considerations set forth in Justice Alito's majority opinion, we decline to so extend the Supreme Court's holding.
>
> The proper exhaustion requirement generally serves two purposes: protecting administrative agency authority and promoting efficiency. *Id.* at 2385. We hold that, in light of these policy concerns, the merits and compliance tests are independent, not cumulative. Satisfaction of either test is sufficient for a finding of proper exhaustion, and a defendant must show failure to meet both tests to succeed on a motion to dismiss for failure to exhaust administrative remedies.
>
> * * * * * *
>
> ... [H]aving an untimely grievance addressed on the merits in the administrative agency's grievance system is just as likely to convince a complainant not to pursue the matter in federal court as having a timely grievance addressed on the merits would be. Lastly, an administrative record is still generated when the agency hears the grievance and appeals on the merits.

Jones, supra, at 1134-38.

All of this makes perfect sense, because the point of the grievance process is not to create mindless procedural hoops that prisoners must jump through, but rather to craft a route by which prison disputes can be resolved quickly and cheaply, before prisoners are allowed to take their claims to court. In this case, as the record makes abundantly clear, Mr. Broder tried to get help speeding up his diagnosis and treatment, to no avail. At the end, he filed a grievance challenging not (or not just) the failure to get a specific medical test, visit, or authorization on time, but challenging instead (or in addition) the underlying policies and procedures that caused the systematic delays in his diagnosis and treatment. That claim was fully and fairly addressed by the MDOC, and Mr. Broder did not file this action until it was clear that no relief would be forthcoming from

the Department. *See* Complaint, Exh. 1, Grievances.[23] Mr. Broder, like the prisoner-plaintiff in *Jones*, "did not commit one procedural error after another in order to have his grievance denied on procedural grounds," *id.* at 1135, so that he could go straight to court.

The case cited and attached by the MDOC defendants is inapposite for the same reason. In *Irving v. Kelly*, E.D. Mich. No. 03-CV-75106, attached to the Defendants' Brief as Exh. 5, Judge Roberts rightly dismissed the prisoner-plaintiff's claim because the MDOC itself had rejected all of the prisoner's grievances as untimely. *Id.*, at 4. It is the MDOC's job to decide if a grievance is timely, or to choose to decide it on the merits even if it is untimely. It is not the job of the federal district courts to decide – four or five years later – whether or not a grievance was timely filed, when the MDOC treated the grievance as timely and fully answered it on the merits. Accordingly, *Woodford* would have no effect on this case even if it were to be applied retroactively.

D. Naming the Defendant and Complete Exhaustion

The MDOC defendants next argue that under current Sixth Circuit law the plaintiff must have named in his grievances all parties whom he later named in his complaint, and must have exhausted "completely" all of his claims. *See* MDOC Defendants' Brief, at 21-24, 27. The short answer to this argument is that – as shown above – the plaintiff *did* fully name and exhaust as to all defendants who could have been sued. The only defendant whom he did not satisfactorily name – according to the Court – was CMS, Inc., which the Court said was not an entity amenable to suit under the Eleventh Amendment. It is not a failure of "exhaustion" that Mr.Broder failed

[23] If the MDOC defendants' arguments were taken at face value, no prisoner could ever bring a "policy-and-practice" lawsuit, because his underlying grievance could only relate back to the most recent event. In effect the prisoner would be required to file endless grievances, day after day, and appeal them all; but long before he could file suit he would be placed on administrative grievance restrictions.

to name CMS with sufficient specificity, if CMS cannot be sued (according to the Court) in the first instance, because of the bar of the Eleventh Amendment.

The only other defendant whom Mr. Boder did not name individually in his July 2002 grievance was director Caruso, whom – according to the Defendants' Brief, at 10 – he could not have named in a grievance because she did not become the director until July 2003. As noted above, director Caruso is a defendant only for purposes of prospective injunctive relief, to assure timely specialty/urgent health care in the future. For this purpose, Mr. Broder must sue the current director. When he files his grievance he cannot predict who that person will be (if and when he ever files suit), and when he finally files suit he cannot then file a timely grievance against that person retroactively. Under the defendants' reasoning, no suit could ever be brought against the director for injunctive relief because the prisoner-plaintiff would be caught in a grievance Catch-22 that would forever close the courthouse door.[24]

Finally, even if there *were* an unresolved issue in this case about naming a defendant or complete exhaustion, this Court should not address the issue. On October 30, 2006, the U.S. Supreme Court heard oral argument in *Jones v. Bock*, 135 Fed. Appx. 837 (6th Cir. 2005), *cert. granted*, 126 S.Ct. 1462 (2006), and *Williams v. Overton*, 136 Fed. Appx. 859 (6th Cir. 2005), *cert. granted*, 126 S.Ct. 1463 (2006). These two cases present exactly the issues raised by the MDOC defendants – the naming of defendants in grievances and complete exhaustion under the PLRA – and a decision is expected from the High Court shortly. Accordingly, even if the Court here thinks there is something left to decide on this issue, it should await the decision in *Jones*

[24] Mr. Broder did the next best thing – he made his July 2002 grievance as broad as it could possibly be, so that it would apply to anyone and everyone who was responsible for the late diagnosis and treatment of his cancer, at any level of the MDOC or CMS. *See* Grievance (7/12/02), List.

and *Williams*.[25]

IV. THE ELEVENTH AMENDMENT AND QUALIFIED IMMUNITY

A. The Eleventh Amendment

The MDOC defendants next argue that a so-called "policy and custom" or "policy and practice" lawsuit can never be brought against a state department *or* state officials because of the Eleventh Amendment. MDOC Defendants' Brief, at 11, n. 15. The defendants are right as to the MDOC, *see Will v. Michigan Dept. of State Police*, 491 U.S. 58 (1989) (a state agency is not a "person" susceptible to suit under 42 U.S.C. § 1983), but are wrong as to state officials. Indeed, if the defendants were right as to state officials, then the constitutionality of state policies and/or customs could *never* be challenged (without the state's consent), and all state policies and customs, as well as all state officials, would be above the law.

A near-at-hand example (showing that the defendants are wrong) is the long-running *Hadix* case. There the plaintiffs challenged a broad array of MDOC policies and customs, especially relating to access to medical care. The named defendants were and are the high MDOC officials who designed or drafted the policies and customs (in the past), and those who approve, authorize, or tolerate them (today). Since the *Hadix* case has been to the Sixth Circuit and to the U.S. Supreme Court multiple times, one would think that if the Eleventh Amendment barred all suits against state officials for damages or for injunctive relief, *see* Defendants' Brief, at 11, then at some point surely the appellate courts would have thrown out the *Hadix* lawsuit on that basis.

What is really happening is that the defendants are simply mis-characterizing Mr. Bro-

---

[25] The Sixth Circuit's "name the defendant" and "complete exhaustion" rules are minority positions in the circuits, *see e.g., Brownell v. Krom*, 446 F.3d 305, 306 (2nd Cir. 2006), *and Kikumura v. Osagie*, 461 F.3d 1269, 1284 (10th Cir. 2006). The conventional wisdom is that the U.S. Supreme Court granted *cert.* in *Jones* and *Williams* out of concern for the Draconian effects of the Sixth Circuit's wayward rules.

der's claims. He is suing the chief medical officer and the regional health care administrator individually because they had the responsibility to make sure that the health care policies and procedures in place at Parnall in 2001-02 were not a proximate cause of the violation of his Eighth Amendment rights. Mr. Broder has shown that by 2001 these defendants had to have been – and a reasonable jury could find that they were – acutely aware that specialty care and urgent care were consistently being denied to prisoners with serious medical problems. Both the risks and the systemic failure were obvious, yet these defendants did nothing to change the policies and procedures or to prevent the near-certain harm that flowed from them.[26] This is a classic "policy and custom" case, and for years state officials have been held liable for damages in exactly these sorts of circumstances, despite the Eleventh Amendment. *See* cases cited in Part I, *supra.*

Mr. Broder's position can perhaps be made clearer by a simple hypothetical. Assume that the MDOC defendants decided to stop providing medical care to prisoners altogether. By policy or custom, the chief medical officer and the regional health care administrator cease filling empty positions and/or fire existing medical staff. The risk of harm to the prisoners would be obvious, and the unconstitutionality of the policy or custom would be apparent. No doctors would be present to commit malpractice, and no lower-level providers could be blamed for the lack of care. Although neither the chief medical officer nor the regional health care administrator ever had the duty to provide direct (hands-on) medical care, surely they could be sued under 42 U.S.C. § 1983 for the Eighth Amendment violation and the foreseeable harm caused by their policy and custom. The aggrieved prisoner plaintiffs could be awarded both damages and injunctive relief.

Mr. Broder's claim here is no different in kind, and not much different in degree. He as-

[26] As noted earlier, if the Court finds that individual knowledge of the plaintiff's specific medical case is necessary, that, too, is present here. *See* Part I, *and* n. 16, *supra*.

serts that defendants Pramstaller and Epp knew of the systemic failure of care and did nothing, and that the polices and procedures that they designed, approved, or tolerated were a proximate cause of the delay in the diagnosis and treatment of his cancer. (And to make matters worse, they had actual knowledge of the delays in his specific case, and still did nothing.) Taking the evidence in the light most favorable to him, a reasonable jury could find in his favor, and award him damages on this claim.

In addition, because Mr. Broder remains incarcerated, and because he could need urgent care at any time, and because the "policies and customs" in place at Parnall in 2001-02 have not been corrected, *see* Exh. Q, *Hadix* Order (2006), he faces the very real risk that exactly the same thing that happened to him in 2001-02 will happen to him again, in 2007 (or beyond). For that reason he seeks *prospective* injunctive relief for the ongoing constitutional violations that exist at Parnall, and that still put him at daily risk of serious harm.[27] For purposes of prospective injunctive relief, all he needs to show is that the violation – the underlying unconstitutional policy or custom – is ongoing, and that a sufficient risk of harm remains to give him standing to bring the claim. Both are present here. Therefore, the Eleventh Amendment is no bar. The Court should deny the MDOC defendants' motion on this basis.

B. Qualified Immunity

The MDOC defendants' last argument is that they should be dismissed from the case on the grounds of qualified immunity. This appears to be a throwaway argument, because by 2001

[27] The very nature of *urgent* medical care is that no particular prisoner can know in advance when his or her need for it will arise. If only prisoners who were urgently sick could seek injunctive relief, then no one ever would – the sick prisoners would not be able to sue on account of their illnesses, and those who were ill in the past (like Mr. Broder) would either be dead, *see* Exh. P (*Hadix* examples), or would be told that they no longer had standing because they were cured. The wrong would be ongoing – capable of repetition yet evading review.

the law had long been perfectly clear that higher-level prison authorities could be liable for health care policies and procedures that violate prisoners' Eighth Amendment rights. *See* Part I, *supra*, *and Estelle v. Gamble,* 501 U.S. 294 (1991).

In this case, it is clear from the ongoing *Hadix* litigation that chief medical officer Pramstaller and regional health administrator Epp were fully aware that the policies and procedures in place at Parnall in 2001-02 were the cause of extreme delays in diagnosis and treatment – across the board – for specialty referrals and urgent care. Moreover, both had actual knowledge of the delays in Mr. Broder's case and did nothing. There is no basis in the record for either defendant to be granted qualified immunity.

CONCLUSION

For the above reasons, the CMS defendants' motion for summary judgment should be denied. The Court should find that there are genuine issues of material fact as to the plaintiff's Eighth Amendment claims. The Court should also find that a reasonable jury could award damages against defendants Pramstaller and Epp in their individual capacities, and that this Court could grant prospective injunctive relief against defendants Pramstaller and Caruso in their official capacities. The Court should schedule the case for trial.

Respectfully submitted,

MICHIGAN CLINICAL LAW PROGRAM

/s/ Paul D. Reingold
363 Legal Research Building
801 Monroe Street
Ann Arbor, MI 48109-1215
(734) 763-4319 **P-27594**
pdr@umich.edu

Dated: January 19, 2007

Proof of Service

The plaintiff's brief in response to the MDOC defendants' motion for summary judgment, and all attached exhibits, were served using the Court's ECF system, which will provide notice by e-mail to all counsel listed on the case caption.

/s/ Paul D. Reingold
Attorney for Plaintiff
pdr@umich.edu

Dated: January 19, 2007

Plaintiff's Index of Exhibits

1. Pramstaller Dep. (Excerpt)
2. Barrett Dep. (Excerpt)