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.,*

Defendants.

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

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

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Statement of Issues Presented

1. Did the primary care physician's late diagnosis and treatment of the plaintiff's throat cancer violate the Eighth Amendment and the Michigan medical malpractice act?

   The plaintiff says yes.

2. Did Correctional Medical Services' policies and procedures, as implemented by its state medical director, violate the Eighth Amendment?

   The plaintiff says yes.

3. Are there genuine issues of material fact as to both questions #1 and #2?

   The plaintiff says yes.

4. Has the plaintiff complied with the state medical malpractice act?

   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). As to a treating physician, he must show that the doctor was aware of his medical needs (or should have been aware of his medical needs by their obviousness) and yet failed to address them. *Blackmore v. Kalamazoo County*, 390 F.3d 890 (6th Cir. 2004); *Terrance v. Northville Regional Psychiatric Hospital,* 286 F.3d 834 (6th Cir. 2002). As to a policy-maker or policy-implementer, the plaintiff must show that the constitutional harm he suffered was a result of the policies or procedures in place, amounting to deliberate indifference to his serious medical needs. *See e.g., City of Canton v. Harris*, 489 U.S. 378, 392 (1989). In this context, deliberate indifference can be shown by proof that the policy maker was aware that inmates "face a substantial risk of serious harm and disregards the risk by failing to take reasonable measures to abate it." *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

To prevail on his state medical malpractice claim, the plaintiff must show negligence – a failure to meet the standard of care – by the treating physician. MCL 600.2169.

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).

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Proceedings to Date

The plaintiff filed his notice of intent under the state med-mal statute on April 29, 2003. He filed this action under 42 U.S.C. § 1983 on December 24, 2003, along with the affidavits of merit required for his supplemental state-law claims. Correctional Medical Services, Inc., (CMS) filed a motion to dismiss on February 23, 2004. The Court dismissed the corporate defendant on September 22, 2004, based on Eleventh Amendment immunity. A week later, on September 30, 2004, the plaintiff moved to amend his complaint to add CMS's Michigan medical director (Dr. Craig Hutchinson) in lieu of the dismissed corporate defendant. The Court granted that motion on October 20, 2004.

The plaintiff filed his amended complaint on December 8, 2004. As to the defendants bringing this motion, the amended complaint was the same as the original complaint, except that Dr. Hutchinson's name replaced "CMS" throughout the document. The pendent state-law claim for medical malpractice against the CMS contract physician (Dr. Bency Mathai) did not change at all. The defendants answered on December 29, 2004. The answer included a notice that the defense would continue to rely on the affidavits of merit (that had previously been filed) as to the state-law med-mal claim.

Discovery then ensued. The parties took advantage of discovery to depose each other's experts at length, including in-depth cross-examination regarding both sides' affidavits of merit as to the med-mal issues. Following discovery, in September 2006, the plaintiff stipulated to the dismissal of one of the CMS contract physicians (Dr. Audberto Antonini). With all discovery concluded, on November 30, 2006, the defendants Hutchinson and Mathai moved for summary judgment. 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 1 and 2 to this brief. 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, instead of duplicating the facts here, the plaintiff will incorporate them into his argument. *See* Argument, Part I, below.

ARGUMENT

Introduction

This case involves a failure of medical care – namely the late diagnosis and late treatment of throat cancer – by the patient's primary care physician (PCP) and the prison medical system.[1] The PCP, Dr. Bency Mathai, admits that as of 8/20/01 she suspected that Mr. Broder had cancer. The plaintiff's experts say that a reasonable internist would have tested for cancer within weeks. 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. Mr. Broder alleges that the failure of care was the fault of the PCP who failed to coordinate and to monitor his care, as well as the fault of the MDOC-CMS system, which all but guaranteed the late diagnosis and treatment.

The plaintiff's claims are narrowly drawn and straightforward. As to the PCP, Mr. Bro-

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[1] To distinguish the two defendants bringing this motion from the state employee defendants who will be bringing a separate motion, the plaintiff will refer to these two defendants as "the CMS defendants."

der says that Dr. Mathai's failure to ensure timely diagnosis and treatment violated the Eighth Amendment and the medical malpractice act, thus giving rise both to a constitutional claim under 42 U.S.C. § 1983 and to a state-law tort claim for medical malpractice.[2] Dr. Mathai, as the primary care physician, was the only hands-on doctor in a position to coordinate and to monitor Mr. Broder's care. She is sued for what she did and what she did not do from the summer of 2001 to March 2002.

As to the CMS medical director, Mr. Broder says that Dr. Hutchinson is responsible for the systemic failure of care that proximately caused the delay in diagnosis and treatment of his cancer, giving rise to an Eighth Amendment claim under 42 U.S.C. § 1983. Dr. Hutchinson had no direct contact with Mr. Broder and did not know him. Dr. Hutchinson is sued because he was the medical director of the contract provider of health care services for all Michigan prisoners; at all relevant times he was responsible for the *policies and practices* governing Mr. Broder's care.

Neither defendant needed to intend to harm Mr. Broder to be held liable under the Eighth Amendment or the state med-mal law. Nor does Mr. Broder make a *respondeat superior* claim. Finally, his damage claims are limited to the extra suffering caused by the delay in his diagnosis and treatment, plus some long-term effects also caused by the more invasive treatment.

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 for Mr. Broder on both his claims, the CMS defendants' motion for summary judgment should be denied.

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[2] Following discovery, the plaintiff agrees that his state-law claims for negligence, gross negligence, and willful and wanton misconduct are subsumed under the medical malpractice statute and can be dismissed.

I. THE EIGHTH AMENDMENT AND MED-MAL CLAIMS AGAINST DR. MATHAI

A. The Operative Facts

Prisoner-patients have limited access to health care. They cannot schedule an appointment or go to the health clinic on their own initiative. As with everything in prison, they must petition to have their needs met. To see medical staff, they 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 – review the kites and provide much of the care. Exh. H, at 13; Exh. I, at 19. In 2001-02, when Mr. Broder had cancer, there was just one primary care physician for the *c.* 1,200 inmates at the Parnall Correctional Facility. Exh. H, at 15; Exh. I, at 11.

Mr. Broder did not know that he had cancer in the spring of 2001; all he could do was describe his symptoms. He recalls 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.[3] 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

[3] Throughout their brief, the defense presumes that the only evidence in the case is what appears in the medical *chart*. That is, they assume that everything the patient said or did was written down accurately and completely, and that if a statement or event was not written down, then it was not said or did not occur. For purposes of their motion, however, the Court must consider *all* the evidence, presented by both sides, and not just the medical chart.

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. Regardless of whether or not a reasonable internist *should* have recognized that Mr. Broder might have cancer on that date, the question is moot because Dr. Mathai *says that she did*. 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.

But she did *not* enter her suspicions into the file. As a result, no one looking at the file would know why she did the prostate exam (which could have been a routine age-related exam) or why she ordered the chest x-ray (which could have been due to his elevated white blood cell [WBC] count). Exh. C, at 17. Moreover, she either did not fill out the form for the chest x-ray (no form was produced in discovery), or, if she filled out the form, she did not ensure that the test occurred. In fact, she admitted that in 2001 her only system for checking to see if such a test had occurred was to look at the chart at the next scheduled visit. Exh. H at 81, 86.

But 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 the test re-scheduled, 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.

A reasonable jury could find either (1) that Dr. Mathai did not suspect cancer 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, *and* her failure to procure the chest x-ray, *and* her failure to discover that the chest x-ray was never performed, *and* her failure to have a process in place to catch such a mistake if it occurred, all evidence deliberate indifference under the Eighth Amendment and/or medical negligence under state law.

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.

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]

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[4] 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. In any event, 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 swallowing, it was not for Mr. Broder's lack of trying to tell her. *Id.*

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.*

On 9/23/01, Mr. Broder wrote directly to Dr. George Pramstaller, the chief medical officer for the Michigan Department of Corrections (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.

Luckily for Mr. Broder, on 10/12/01, Dr. Audberto Antonini, a visiting physician from another facility, filled in for Dr. Mathai, who was on vacation. Dr. Antonini did a thorough history and 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. That very day Dr. Antonino filled out two referral forms requesting approval for specialty care with both ear-nose-throat (ENT) and gastro-intestinal (GI) specialists to rule out throat or stomach cancer. He marked both 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. Dr. Antonini said that 30 days was a reasonable time to get a confirmed diagnosis. *Id.*, at 22. But far from having a diagnosis within 30 days, the ENT specialty care consult was not even scheduled for 30 days, and the GI consult was not scheduled for 37 days.[6] Because Dr. Antonini was only filling in for Dr. Mathai for one day, however, the duty to follow-up with Mr. Broder's care reverted to Dr. Mathai. Exh. J, at 7-10, 12. As the defense appears to concede, 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

[6] 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.

made urgent referrals for both.[7] 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.

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 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.

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.*

On 11/6/01 the barium swallow and chest x-ray (ordered by Dr. Antonini) were done and were negative for stomach or lung cancer, but an EGD test still needed to be done to rule out the stomach cancer. On 11/13/06, Mr. Broder finally saw an ENT, who found lesions on both vocal

[7] 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.

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 and signed more blood results showing a high WBC count, 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.

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. But 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 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.

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.

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 12/10/01she did review another lab report about his high WBC. Exh. D, at 23. 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. 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 be clear, Dr. Mathai was the only person in a position to coordinate and to monitor Mr. Broder's care. She 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 by these acts and omissions Dr. Mathai violated Mr. Broder's right to be free from cruel and unusual punishment, and that she committed medical malpractice.

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 her <u>22 weeks</u> 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,[8] & 3/26/02, Mr. Broder's treatment did not *begin* for almost 2½ more months. On 1/30/02, Dr. Mathai prescribed

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[8] 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.

Mr. Broder Ultram for his throat pain and Resource for his weight loss. Exh. D, at 35-36. The Ultram was not dispensed because it was an "off-formulary" request and required approval from CMS. Exh. D, Form 122, at 37. Also, 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.[9] 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. Mr. Broder still did not have either the pain medication or the nutritional supplement that Dr. Mathai had prescribed the week before. Exh. E, Kite 2/4/02. 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. (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 re-

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[9] 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.

questing 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 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.[10] 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 for her to get a diagnosis, and in the 6½ weeks

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[10] 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.

since Mr. Broder still had not completed the *pre*-treatment protocols. Exh. D, at 55.

After Dr. Mathai went on maternity leave on 3/8/02, things finally sped up slightly. On that day a Foote radiation oncologist again requested a CT scan, marked "Urgent." 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, Dr. _____ Bey – Dr. Mathai's replacement as the primary care physician in the facility – 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.[11] The MRI, done on 3/27/02, confirmed Stage III cancer. Exh. D, MRI Results, at 81-82. Stage III cancer requires chemother-

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[11] The transcript reads, "I am no<u>t</u> concerned about his airway," but the chemotherapist testified: "I think that's a typographical error. I was – it should be, I am no<u>w</u> 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).

apy 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, Interval 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*.

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.

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 as to Dr. Mathai

At bottom, the defense argues that Dr. Mathai did nothing wrong because she filled out the appropriate forms.[12] But a PCP’s duty is not to fill out forms, but to ensure timely diagnosis

[12] Mr. Broder disputes even this, as often the forms were filled out late, or were forwarded to CMS late, or were approved late, or were not filled out and sent at all, with no follow-up by Dr. Mathai.

and treatment of her patient. Exh. M, at 66. As the plaintiff's expert put it, "... [S]he signed the forms, and yet the work-up was proceeding at a snail's pace." Everything was "way too slow." Exh. M, at 54, 18. Given the system of patient care at the Parnell Facility in 2001-02 , a reasonable jury could find that *only* the PCP was in a position to coordinate and monitor Mr. Broder's care. In the end, the buck stops with the primary care physician, who has the primary responsibility, as even the defense witnesses acknowledge:

> Q. What I'm asking is, it remains the primary care physician's responsibility to make sure that the consult occurs within the period of time that ... is appropriate for the case that's needed?
>
> A. Or to – or to get an answer – or to be aware of why it is not happening.
>
> * * * * * *
>
> Q. And I take it from that, that if the period of time for the scheduling exceeds what either the [PCP] thought was appropriate or what the specialist wrote was appropriate, then it remains incumbent on the [PCP] to find out why there's a delay?
>
> A. Yes.

Exh. O, Defense Exp. Norman Dep., at 66; Exh. F, Defendant Pramstaller Dep., at 15. *See also* Exh. M, at 54. In this case, the *best* thing that Dr. Mathai did for Mr. Broder was (1) to go on vacation in October 2001, and (2) to go on maternity leave in March 2002. Harsh as it sounds, only in her absence did Mr. Broder get the medical care he needed.

The controlling law in cases like this one is straightforward. Where a doctor knows the nature and duration of the plaintiff's condition, and knows that the plaintiff requires medical attention, and fails 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) (viewing the facts in the light most favorable to the plaintiff, a reasonable jury could conclude that defendants were aware of facts from which the inference could be drawn that a substantial risk of serious harm existed and the defendants ignored that risk; defendants had a sufficiently culpable state of mind to meet the subjective prong of the deliberate indifference test). *Black-*

more stands for the further proposition that where the seriousness of a prisoner's need for medical care is obvious, the constitutional violation is not premised upon the detrimental effect of the delay, but rather that the delay alone creates a substantial risk of serious harm. *Id*. at 899. Here the delay caused months of unnecessary pain and fear, more invasive treatment, and permanent harm. Exh. N, at 85-88; Exh. G, at 129, 136-41. *See also Boretti v. Wiscomb*, 930 F.2d 1150, 1154 (6th Cir. 1991) (having to endure physical pain and mental anguish during the time of delayed care constitutes cruel and unusual punishment within the meaning of the Eighth Amendment); *Parrish v. Johnson*, 800 F.2d 600, 610 (6th Cir. 1986) (actual injury is not a necessary predicate to damages for an Eighth Amendment violation).

Moreover, an Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; 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 a prison official 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 Mr. Broder – a patient whose own doctor says that she thought he had cancer on 8/20/01, but who failed to get a confirmed diagnosis for five months, and failed to start treatment for 7½ months. Where the need for medical care is obvious, care which is so cursory as to amount to no treatment at all amounts to deliberate indifference. *Id.* at 843-44, *citing Mandel v. Doe*, 888 F.2d 783, 789 (11th Cir. 1989).

Here, both the subjective and objective parts of deliberate indifference have been met. To satisfy the subjective component of the adequate medical care test, an inmate must demonstrate that the official in question subjectively perceived a risk of harm and then disregarded it. *John-*

son v. Karnes, 398 F.3d 868, 875 (6th Cir. 2005). Here we know Dr. Mathai thought that her patient had cancer but did not get him timely diagnosed or treated. Even using the objective standard, a genuine issue of material fact as to deliberate indifference can be based on a strong showing that the need for care was objectively obvious. *See Carter v. City of Detroit*, 408 F.3d 305, 313 (6th Cir. 2005).

C. Applying State Med-Mal Law to the Facts as to Dr. Mathai

Given that Dr. Mathai's acts or omissions rose to the level of deliberate indifference, they necessarily include negligence. The plaintiff's expert could not be clearer that Dr. Mathai failed to meet the requisite standard of care. "She missed the diagnosis [in August]. ... Once [cancer] was suspected, she did nothing to facilitate Mr. Broder's getting care in a timely manner." Exh. M, at 39. The parties agree that the standard of care is the same for those in prison as for those on the outside. Exh. O, Def. Expert Norman Dep., at 100-01. 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?
>
> 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, the MDOC chief medical officer, 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.

Exh. F, at 36. Dr. Pramstaller also agreed that the *responsibility* remained with Dr. Mathai:

Q. Is it fair to say that it's the assigned doctor's [PCP's] job to make sure that patient gets the treatment that the patient needs? [Objection omitted.]
A. I believe so, yes.

Id., at 15.

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 Dr. Kornak's request on 11/13/01 for biopsy surgery within 2-3 weeks, we know that surgery did not occur for two months. Dr. Pramstaller addressed exactly this point:

Q. ... you told me before that, in the end, the primary care physician has the responsibility for making sure that the care happens, and here we've got a specialist saying I want this operation concluded at the end of three weeks, and we know the scheduling isn't even going to be requested until after that time has run.
I want to know, how does the primary care physician monitor this to make sure that now it happens and it happens fast?
A. Well, she could monitor it through a tickler file that they keep themselves of patients they want to follow up on, or they can just walk into the other room where the CMS coordinator is and take a look at the off-site specialty book which should give you up-to-date information on that.
Q. So either of these were available to Dr. Mathai to do?
A. That's correct.

Exh. F, at 65. Instead Dr. Mathai signed a form that allowed the case not to come back to her attention for more than 30 days:

> A. Her signing the [30-day] form, as I currently understand it and as it has been stated, moves the diagnostic procedures well past the time window recommended by the [ENT], so she *could not do so without consulting with the sub-specialist*.

Williams Dep., Exh. M, at 96 (emphasis added). Doing so is "outside the standard of care." *Id.*

The MDOC medical director appeared to agree. Dr. Pramstaller testified:

> Q. Is it appropriate at this point for her to sign a 30-day deferral form? [Objections omitted.]
> A. If I was reviewing this case, I would have questions as to whether or not it was appropriate, and I would probably talk to her.
> * * * * * *
> Q. If we look at the second [30-day deferral] form, this one is dated January 2, [200]. ... If it was a problem on November 29th, is it a significantly greater problem on January 2nd? [Objections omitted.]
> A. I would have more concern over it, yes.

Exh. F, at 69.[13]

Regarding his own audits of primary care physicians, Dr. Pramstaller said he would ask:

> A. ... did the primary care doctor, or provider ... do everything that was within their power to see that [care] got expediated [*sic*]. In other words, did they pick up the phone and call the specialist, did they try to change the appointment ..., did they make an effort to do that.

Exh. F, at 22. The evidence shows that none of these things occurred. The procedures may have contributed to the lack of care, but in the end the duty was Dr. Mathai's:

> Q. ... you're saying there is a whole procedure here, and someone is responsible for it taking too long, but the overall time is not necessarily Dr. Mathai, right?
> A. *I believe the bulk of ... it does fall to the primary care provider, in this case Dr. Mathai.*

Exh. M, at 82-83 (emphasis added).

After Mr. Broder's cancer was diagnosed, Dr. Mathai failed to ensure that his treatment

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[13] The plaintiff has submitted Dr. Pramstaller's deposition testimony in its entirety. If the Court is going to read one attachment with care, that is probably the one to read. *See* Exh. F.

went forward in a timely manner. 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. At the least there are genuine issues of material fact, so that summary judgment should not be granted.

II. THE EIGHTH AMENDMENT CLAIM AGAINST DR. HUTCHINSON

A. The Evidence from the Record

The claim against Dr. Hutchinson 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) 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 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. And even if the forms *were* approved, the appointments were not timely scheduled (within the limits set by the requesting doctors), and the actual appointments remained subject to cancellation due to transport problems, faulty equipment, *etc*. Over and over again the record shows that the prison medical system *could not pro-*

vide 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 it after the fact). Exh. C, at 7. Otherwise nothing happened.

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

Another 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 Dr. Hutchinson.

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 kite system was also dysfunctional.

B. The *Sweeton* Evidence

The delays in Mr. Broder's diagnosis and treatment were not aberrations, but were part of a systemic failure of care with which Dr. Hutchinson was 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.[14] 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 hear-

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[14] 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.

ing 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):[15]

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" perform-

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[15] 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.

ance 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 Dr. Hutchinson 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.

III. THE MEDICAL MALPRACTICE PROCEDURAL ISSUES

The CMS defendants raise several procedural or technical issues of state law. A close reading of their brief, however, shows that the bulk of the text is boilerplate that – while it may apply in other cases – has little relevance here. Each issue will be addressed briefly below.

A. The Affidavit of Merit and the Amended Complaint

The defense first argues that Mr. Broder's med-mal claim must be dismissed because he failed to file an affidavit of merit *with his amended complaint*. Defendants' Brief, at 23-27.

Mr. Broder's original complaint and affidavits of merit could not have been clearer that he intended a medical malpractice claim to run against his PCP for any delays in his diagnosis and treatment attributable to her. *See* Exh. R, Complaint; Exh. S, Affidavits of Merit. When the Court dismissed CMS as a defendant on Eleventh Amendment grounds, Mr. Broder sought and got leave to amend his complaint to add CMS's medical director as a named defendant in its

stead.[16] No other claims or parties were changed. The amended complaint simply inserted Dr. Hutchinson's name wherever the name CMS, Inc., had appeared in the earlier version – in all other respects it was identical.

Following discovery, the plaintiff agreed to voluntarily dismiss his claims against Dr. Antonini, who plainly was not at fault. Dr. Mathai is now the only treating physician left in the case being sued for medical malpractice. Mr. Broder filed an affidavit of merit in support of his original complaint as to her, and nothing in the amended complaint changed as to her. Indeed, in her answer to the amended complaint, Dr. Mathai adopted the defense affidavits of merit filed *in response to the original complaint*. Thus, Dr. Mathai and her attorneys clearly knew that she had been sued for medical malpractice, and that the core of Mr. Broder's claim was her delay in the diagnosis and treatment of his cancer.

The defendants rely on cases that are inapposite. In *DeMann v. Detroit Osteopathic Hospital Corp.,* 2001 U.S. Dist. LEXIS 19260 (W.D. Mich. 2001), and in *Judd v. Heartland Heartland Health Care Center*, 2001 U.S. Dist. LEXIS 21747 (E.D. Mich. 2001), the plaintiff failed to file an affidavit of merit with his *original* complaint. The courts said that the plaintiff could not cure the defect by filing the affidavit with the amended complaint. Likewise in *Nippa v. Botsford Gen. Hospital*, 251 Mich. App. 664 (2002), 257 Mich. App. 387 (2003), the claim was dismissed because the plaintiff never filed an affidavit of merit from an appropriate specialist, as the court found was required under the circumstances. These cases are the reverse of what happened here, where the plaintiff's affidavit of merit *was* filed with the original complaint, and where the claim *and* the defendant did not change in the amended complaint.

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[16] At the same time, he dropped several doctors whose relationship with the MDOC or CMS had been unclear when he had filed his initial complaint.

A much closer case is *Derfiny v. Bouchard*, 128 F. Supp. 2d. 450 (E.D. Mich. 2001) , *remanded on other grounds*, 106 Fed.Appx. 929 (6th Cir. 7/6/04). There the plaintiff filed timely affidavits of merit against the doctors, but did not re-file the affidavits when the case was consolidated with a case against the hospital that employed them. The district court denied the hospital's motion to dismiss, noting that as to the hospital "the medical malpractice claim is based on a theory of vicarious liability arising out of the same acts and omissions" pled in the initial suit. *Id.*, at 452. The court held that where the same lawyers represented both sets of defendants, and where the original affidavits stated that the doctors and the "health facility" had breached the standard of care, and where there was no prejudice to the defendants, dismissal was improper. *Derfiny* is a much harder case than here, because the affidavit of merit had to run against a new defendant in the consolidated cases, where here it runs against the *same* doctor (Mathai) as in the initial complaint.[17]

Citing *Vandenberg v. Vandenberg*, 231 Mich. App. 497 (1998), the *Derfiny* court also noted that the purpose of an affidavit of merit "is to deter frivolous malpractice claims." *Id*., at 452. The court concluded that where, as here, the defendant and its attorneys already had notice of the plaintiff's underlying claim, and were in possession of affidavits of merit which substantially complied with the purpose of the statute, and where the claim derived from the same acts and omissions of the same doctors as in the earlier case, the affidavits of merit were sufficient. This Court should do the same thing.

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[17] Although Mr. Broder's affidavits of merit address the duties, responsibilities, and standard of care for "a health care provider," Exh. T, he did not plead vicarious liability as to Dr. Hutchinson (nor did he get an affidavit of merit regarding the duties of a senior health care administrator). Mr. Broder has treated the claim against Dr. Hutchinson as arising only under the Eighth Amendment, for constitutionally deficient policies and practices and/or training and supervision. Accordingly, Dr. Mathai is the only defendant against whom the med-mal claim runs.

B. The Specificity of the Notice of Intent

The defense complains that the plaintiff's notice of intent was insufficient for lack of specificity. But the standard for the notice of intent is a lenient one. As the defense notes, all that is required is that the plaintiff make "good faith averments ... consistent with the early notice stage of the proceedings." Defendants' Brief, at 28, citing *Roberts v. Atkins*, 470 Mich. 679, 691 (2004). The expected level of specificity must be considered in light of the fact that discovery has not yet begun. *Id.* Especially when the plaintiff is a prisoner, he often does not and cannot know with any precision who was responsible for his care. In fact, for security reasons, prisoners are intentionally kept in the dark about their appointments, and often they have no idea who is doing what in relation to their care. Exh. N, at 27.

Mr. Broder's state-law claim was (and is) about as simple as a med-mal claim can be. At bottom, his notice of intent says that his care providers failed to diagnose his cancer, then (when they thought he had cancer) failed to get confirmation for months, then (once he *was* diagnosed) failed to get him treated for months. Exhs. R and S. This is not rocket science.

A quick look at the plaintiff's notice of intent shows that he fully complied with the statute. *See* MCL 600.2912b(4). He laid out the factual basis for his claim, describing in some detail the delays in the diagnosis and treatment of his cancer. He stated the outside time frames (from discrete events) beyond which no reasonable doctor could go without being negligent. He made clear that his care providers did not ensure the timely diagnosis and treatment of his cancer, and that this was the basis for his claim. He alleged harm as the proximate result of the delays, including added suffering from the delay itself. Exh. S, at 1-5.

Mr. Broder went overboard in making it clear that his notice applied "to the health care professionals, entities, and/or facilities, as well as their employees or agents, actual or ostensible,

who were or are involved in [his] treatment" *Id.,* at *6.* He listed 15 known individuals (including Drs. Mathai and Hutchinson), as well the MDOC and the corporate provider CMS, Inc., and he asked that the notice be given "to any person (or entity) not specifically named in this notice" who reasonably might be encompassed within claim. *Id.* (The notice also asked for *legible* copies of Mr. Broder's medical file – something he had not been able to procure to that point, with the result that much of the medical data he had – especially who had done what when – remained cryptic.)

Citing *Roberts*, the defense complains that the notice must identify "a specific standard of care applicable to each of the 17 different persons concerned in the NOI." But the defendant here is just one person – the primary care physician. Reading the notice of intent, its message to *her* could not be clearer: that she failed to ensure that Mr. Broder was diagnosed and treated within a reasonable time. The defense wants the Court to read the notice of intent as if Dr. Mathai were unaware that she was the primary care physician responsible for Mr. Broder's care. Relying on *Roberts*, the defense tries to complicate matters, and then seeks shelter in the complications of its own making.

Again, a case more on point is *Boodt v. Borgess Medical Center*, __ Mich. App. __, 2006 WL 3085755 (10/31/06). There, even though the notice of intent did not identify a defendant by name in describing how a certain harm was caused, the court found the notice sufficient, because the defendant would know that he was the person who performed the harm-causing surgery. In the same way, Dr. Mathai knew that she was the only primary care physician responsible for ensuring that Mr. Broder's cancer was timely diagnosed and treated.

The *Boodt* court emphasized that the notice of intent must be viewed as a whole, and that no particular format need be followed. To borrow from the text of *Boodt*, any reader who knew

that Dr. Mathai was serving as Mr. Broder's primary care physician "could not help but become aware of the specific breaches being alleged against" her. *Boodt*, at *4.

The same is true of the alleged lack of specificity about what Dr. Mathai "should have done" differently. As the Court said in *Roberts*, if (for example) the notice of intent alleged that a physician amputated the wrong limb, "it would be obvious to the casual observer" that the physician should have amputated the correct limb. *Boodt*, at *4, quoting *Roberts*, at n. 12. Once Mr. Broder described the malpractice as the delay in his diagnosis and treatment, then both the breach of duty and the corrective action were obvious – that Dr. Mathai should have coordinated and monitored his care to ensure *timely* diagnosis and treatment. As the *Boord* court found, "It strains credibility to conclude that [the defendants] would not understand the nature of the suit against them on the basis of the notice of intent here." *Boodt,* at *5. All of the defense arguments about the notice of intent here are of a similar ilk, and the answer to each is the same: it strains credibility to conclude that Dr. Mathai or her attorneys would not understand the nature of the suit against her on the basis of the notice of intent filed by Mr. Broder.[18]

C. The Affidavit of Merit

The defense makes essentially the same argument as to the affidavit of merit, and the argument should fail for the same reasons. Like the notice of intent, the affidavit of merit is also filed before discovery, with the complaint, when information available to the plaintiff is limited.

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[18] The *Boodt* court did find the notice of intent deficient as to the hospital, because the notice failed to show how the hospital "had any factual involvement in the underlying events." If the notice of intent here were arguably deficient in any way, it would be as to Dr. Hutchinson, who was substituted in for CMS in the amended complaint. Mr. Broder never submitted affidavits of merit from experts in prison medicine as to the policies and procedures designed or implemented by Dr. Hutchinson, so a state law med-mal claim – as opposed to an Eighth Amendment claim – arguably could not go forward as to him, for lack of meeting that statutory requirement. *See* n. 15, above.

See e.g., Zemaitis v. Spectrum Health, 2006 Mich. App. Lexis 1087 (4/6/06) (attached), at *14; *Boodt*, at *5. Its purpose, too, is to prevent frivolous filings. At present, the only remaining defendant is Dr. Mathai, and since she *was* a general practitioner, internist, or health care provider – and since she knew that she was the primary care physician – it is hard to see how she could possibly have been confused about what the plaintiff was alleging that *she* did wrong, or what she should have done in order not to be negligent. As the *Vandenberg* court noted, "dismissal of a claim is a drastic sanction that should be taken cautiously." *Id.* at 502. Mr. Broder's affidavits fully covered the statutory waterfront, and do not warrant dismissal of his med-mal claim against Dr. Mathai.[19]

D. The Issue of Proximate Cause

Lastly, the defense argues that the notice of intent and affidavits of merit are deficient on the issue of proximate cause. The defense again cites *Roberts*, as well as *Bailey v. Pornpchit*, 2006 Mich. App. LEXIS 2459 (8/8/06). But in both those cases the precise question was *how* the defendants caused the alleged harm. In one case, the plaintiff was rendered unable to have children, and in the other case the plaintiff's child was stillborn. In both cases the court insisted that *some* allegation be made (beyond a general claim of negligence) to show a causal connection between the alleged negligence and the alleged *specific* harm.

Mr. Broder's case is quite different, because the proximate harm he alleges was having to endure the pain and suffering of his symptoms for far longer than he should have had to endure

[19] The Court also should not reward the gamesmanship inherent in the defense motion. The notice of intent and affidavits of merit were filed back in 2003, at the start of the case. The defense at any time could have moved to dismiss based on the same alleged deficiencies, if it believed them to be meritorious. Instead, the defense waited until all the discovery was done – at considerable expense to everyone – and makes the motion now only because dismissal will time-bar the plaintiff's med-mal claim. Even in a case where the notice or the affidavit of merit truly *were* defective, the Court might want to condition a dismissal on the payment of costs, for the unnecessary discovery occasioned by the defendants' delay.

them, and having to undergo more invasive treatment than otherwise would have been necessary. When the alleged negligence is the failure to timely diagnose and treat, and the proximate harm is the suffering caused as a result, there can be no "extra step" or "extra proof" required because the causal connection is direct. Similarly, if a doctor amputates the wrong arm, the plaintiff need not allege *how* the doctor's negligence was the proximate cause of his injury – the nature of the claim itself eliminates the need for any such "intermediate" step. Again, what we have in Mr. Broder's case is the opposite of the situation presented in *Roberts* and *Bailey*.

Here the defense of course may dispute whether or not Dr. Mathai was the responsible physician, or whether or not the late diagnosis and treatment resulted in added pain and suffering. But these are jury questions that have nothing to do with the framing of proximate cause in the notice of intent or in the affidavit of merit. In the same way, the surgeon accused of amputating the wrong arm might argue – long after the notice of intent and the affidavit of merit are filed – that he did not perform the surgery, or that someone else "marked" the wrong arm. These, too, can only be viewed as jury questions, and not as issues of "proximate cause" like those raised in *Roberts* and *Bailey*.

Moreover, in his notice of intent and in his affidavits of merit, Mr. Broder alleged that as a result of the delays, his cancer progressed from Stage I to Stage III. Exh. S, at 4-5; Exh. T, at 4; *see also* Exh. K, at 27. His experts – who volunteered to assist in this case after reviewing the file and who are not being paid by the plaintiff – maintain that position following discovery. Exh. B, at 11-13; Exh. N, at 71-73. Thus, even if "specific" allegations of proximate causation were needed in a case of this sort, they were in fact submitted. *Id.* Accordingly, both the issues

of causation and harm have been addressed.[20]

IV. Mr. Broder's Medical Expert's Opinion as to the Med-Mal Claim

The defense's last argument is that Mr. Broder's medical expert's opinion does not support the medical malpractice claim. To reach this conclusion, the defense reads the evidence in the light most favorable to the defense,[21] and even then the argument does not hold water. All that the Court has to do is read Dr. Williams' expert report, which Dr. Williams confirms in his deposition. *See* Exh. 1, at 9-11, Opinions and Conclusions; Exh M.[22]

As to the tardy *diagnosis*, Dr. Williams found (1) that Dr. Mathai had enough information to be able to make a differential diagnosis of throat cancer by the end of August 2001; (2) that Dr. Mathai should have had a *confirmed* diagnosis within a few weeks; (3) that Dr. Mathai failed to test for throat cancer and did not complete the tests that she ordered to rule out other cancers; (4) that after Dr. Antonini saw Mr. Broder on 10/12/01, Dr. Mathai should have gotten a confirmed diagnosis within 30 days; (5) that after the ENT saw Mr. Broder on 11/13/01, Dr. Mathai approved 30-day delays that extended the earliest date for a confirmed diagnosis far beyond the

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[20] Mr. Broder's damage claim is not just that he had to undergo chemotherapy that could have been avoided, but also that the wider field of radiation (to treat Stage III cancer) caused added damage to his throat, voice-box, and salivary glands. Exh. N, at 85-88. He also faces a much higher mortality rate if his cancer recurs. Exh. 2.

[21] For example, the medical record shows (for Mr. Broder's 7/11/01 annual health screen) ongoing cold/ sinus problems for 2-3 weeks, and a cough lasting longer than three weeks. The defense implies that the annual screen should be completely ignored because the nurse never wrote down the magic words "sore throat." Of course, Mr. Broder's testimony, confirmed by his kites, letters, and grievances, is that he had a more or less constant sore throat from April 2001on, and that he tried several times between May and August to get a doctor visit. *See* Part I, above.

[22] Since the plaintiffs' experts' reports were the subject of cross-examination in the depositions, and were fully adopted (at least by implication) in the depositions, the plaintiff assumes that they will be treated as the doctors' formal opinions for purposes of this motion. To be certain that they are, the plaintiff will also submit in the next ten days short affidavits from the two experts (Williams and Bradford) adopting their expert reports as sworn statements.

2-3 weeks that the ENT had requested; and (6) that her failure to get a confirmed diagnosis until mid-January 2002 far exceeded the standard of care in any setting in southeast Michigan. *Id.*

As to the tardy treatment, Dr. Williams opines that Dr. Mathai should have ensured that Mr. Broder's treatment *started* within four weeks of the mid-January diagnosis date, and that waiting until April 2-3, 2002, far exceeded the standard of care. The defense's selective quotes from the deposition notwithstanding – most of which are qualified by the expert – a reasonable jury could find that Dr. Williams's testimony fully supports a claim of medical malpractice.

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 both the Eighth Amendment and the med-mal claims, and should schedule the case for trial.

Respectfully submitted,

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Dated: December 21, 2006

Proof of Service

The plaintiff's brief in response to the CMS 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
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Dated: December 21, 2006

Plaintiff's Index Exhibits

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A. Expert report of Brent Williams, M.D.

B. Expert report of Carol Bradford, M.D.

C. Mr. Broder's medical "chart" (including a more legible typed version)

D. Mr. Broder's medical records

E. Mr. Broder's grievances, kites, and related communications

F. Deposition of George Pramstaller (excerpts)

G. Deposition of Steven Broder (excerpts)

H. Deposition of primary care physician Bency Mathai (excerpts)

I. Deposition of CMS medical director Craig Hutchinson (excerpts)

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K. Deposition of consulting radiologist James Hayman (excerpts)

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