No. 06-1414

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

DIEGO GIL,	)	Appeal from the United States
	)	District Court for the Western
	)	District of Wisconsin
	)	
Plaintiff-Appellant,	)	Case Number 00-C-0724-C
	)	
v.	)	
	)	
JAMES REED,	)	Hon. Barbara B. Crabb
JAIME PENAFLOR, and	)	
UNITED STATES OF AMERICA,	)	
	)	
Defendants-Appellees.	)	

BRIEF FOR PLAINTIFF-APPELLANT DIEGO GIL

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Appellate Court No: 06-1414

Short Caption: Diego Gil v. James Reed, Jaime Penaflor, and United States of America

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JURISDICTIONAL STATEMENT

Plaintiff has raised claims pursuant to the Federal Tort Claims Act ("FTCA"), 28 U.S.C. § 2671 *et seq.*, and the Eighth Amendment, pursuant to *Bivens v. Six Unknown Named Agents*, 403 U.S. 388 (1971). The United States District Court for the Western District of Wisconsin had jurisdiction under 28 U.S.C. §§ 1331 and 1346(b)(1). This Court has jurisdiction under 28 U.S.C. §§ 1291 and 1294. The final judgment of the district court, disposing of all claims against all parties, was entered on January 6, 2006. Plaintiff filed a timely notice of appeal on February 3, 2006.

ISSUES PRESENTED FOR REVIEW

1. Whether Defendant Penaflor violated Plaintiff's Eighth Amendment rights by, for no legitimate reason, refusing to give Plaintiff a prescribed antibiotic to treat a golf-ball sized infection.

2. Whether Defendant Reed violated Plaintiff's Eighth Amendment rights by, immediately following Plaintiff's rectal prolapse surgery, cancelling two of the three laxatives prescribed by the specialist surgeon and substituting Tylenol III for Vicodin, even though the surgeon had specifically warned Plaintiff that he should not take Tylenol III because it increases constipation.

3. Whether Plaintiff has created a genuine issue of material fact as to his medical malpractice and common-law negligence claims under the FTCA based upon the inadequate care provided by Reed, Penaflor, and others.

STATEMENT OF THE CASE

Diego Gil is a federal prisoner suffering from a severe rectal prolapse — a painful condition in which the rectal wall protrudes from the anus, usually during bowel movements. To correct this condition, Gil has required multiple surgeries. This case involves whether several physicians, notably Dr. James Reed, and their assistants, in particular Mr. Jaime Penaflor, violated Gil's Eighth Amendment rights, committed medical malpractice, and/or acted negligently in failing to treat Gil's medical needs adequately.

Two years ago, in *Gil v. Reed*, 381 F.3d 649 (7th Cir. 2004) (SA328-SA352),[1] this Court held that Gil, proceeding *pro se*, was entitled to counsel and had presented sufficient evidence to warrant trial on his Eighth Amendment and FTCA claims. In so holding, this Court explained:

- "Penaflor's angry and unexplained refusal to give Gil his prescribed medication is sufficient to create a genuine issue of fact regarding his state of mind" (SA346-SA347) and was "enough to survive summary judgment" on Gil's Eighth Amendment claim against Penaflor (SA348);
- Dr. Reed's decision to deviate from a colorectal specialist's prescriptions immediately following rectal prolapse surgery in a manner that increased Gil's constipation (switching one pain medication for another with more constipating side effects and cancelling other medications designed to

[1] Citations to the required short appendix are denoted "A." Citations to the separate appendix are denoted "SA."

reduce constipation) — despite specific warnings by the specialist — was enough to survive summary judgment on Gil's Eighth Amendment claim against Reed (SA348-SA351); and

- "Gil's FTCA claims should survive summary judgment" (SA343).

On remand, Defendants submitted a new expert report by Dr. Jeffrey Harms, deposed Dr. Michael Kim (a colorectal specialist whose declaration Gil had relied upon previously), and submitted new declarations from other individuals. Defendants again moved for summary judgment, claiming that the new evidence proved that trial was unwarranted. The district court granted the motion. Gil now appeals the district court's decision.

STATEMENT OF FACTS[2]

Plaintiff Diego Gil has been incarcerated at the Federal Bureau of Prisons ("BOP") since June 4, 1993. SA5 (¶11); SA103 (¶1). He was temporarily held at a Chicago facility but was transferred on June 27, 1994, to the Federal Correctional Institution at Oxford, Wisconsin ("FCI-Oxford") where he has spent most of his custodial time. SA103 (¶3). Defendant James Reed is a physician and the clinical director at FCI-Oxford. SA385 (¶1). Defendant Jaime Penaflor is a physician assistant at FCI-Oxford. SA388 (¶1).

Gil had been suffering from intestinal and colorectal illness long before he arrived at FCI-Oxford. SA5-SA7 (¶¶12-31); SA103 (¶3). While he was held at the

[2] The facts of this case are fully recounted in this Court's prior opinion. SA329-SA334.

Chicago facility, he required surgery to repair a bleeding ulcer. SA7 (¶29); SA103 (¶3). Soon after, Gil began to bleed profusely from the rectum and, as a result, received several blood transfusions. SA7-SA9 (¶¶33-40). When he was transferred to FCI-Oxford, he reported his condition to the medical staff. SA106 (¶¶16-19).

In early March, 1998, Gil was taken to the hospital to be examined. SA107 (¶24); SA393 (¶4). The team of surgeons confirmed that Gil suffered from a severe rectal prolapse: a painful condition where the rectal wall protrudes from the anus, usually during bowel movements. SA107-SA108 (¶¶23-27).

On March 6, 1998, Gil had surgery to repair the prolapse. SA108 (¶28). The surgeon, Dr. Robert McDonald, utilized an "abdominal approach," which meant repairing the prolapse by entering through the abdomen. SA456. On March 11, after five days of recuperation, Gil returned to FCI-Oxford. SA109 (¶35). Eight days later, on March 19, Gil complained to a housing officer about severe pain around the location of his recent surgical incision. SA110 (¶39). The officer contacted a superior at the Lieutenant's Office at 11:30 pm, requesting emergency medical assistance for Gil. *Id*. He was informed that FCI-Oxford no longer provided 24-hour medical care. SA110 (¶¶39-41). Thus, Gil was not seen by medical personnel that evening. SA110 (¶39).

It was not until the next day, Friday, March 20, that Gil was examined by a member of the medical staff, Physician Assistant Kedrow. SA110 (¶¶42-43). Gil complained to Kedrow about severe pain in the area of his recent surgical incision. *Id*. Kedrow "was dismissive and curt" to Gil and gave him a brochure explaining how to perform back exercises. *Id.* When Gil doubted the efficacy of this recommended

treatment in light of his recent major surgery and showed Kedrow a bulge in the area of his surgical incision, Kedrow "told [Gil] that he was through and ordered [Gil] to return to [his] unit." *Id.*; SA439 (¶7). Gil complained to prison staff, Lieutenant Turvey, about Kedrow's refusal to treat the severe pain and tenderness at the site of his incision, but Turvey responded that he had no authority over the actions of the medical staff. SA111 (¶44).

Several more days passed before Gil was able to receive treatment. SA111 (¶46). Because Gil could not see medical staff over the weekend, Kedrow's refusal to provide treatment on Friday, March 20, meant that Gil was forced to wait until the following Monday, March 23, before he could be examined by the medical staff. *Id.* During that weekend, Gil suffered chills, pain, and could not sleep. SA111 (¶¶46-47). His infection developed into a golf-ball sized bulge. SA439 (¶9). When he was finally seen by medical staff on the 23rd — five days after he had sought treatment for his pain and tenderness — the infection had progressed such that it required lancing and draining, and Gil was prescribed Cephalexin, an antibiotic, and Tylenol III, a painkiller. SA111-SA112 (¶47); SA390-SA391 (¶3). Gil was instructed to begin taking the medication immediately and was told that it would be waiting for him in the medication line that evening. SA111-SA112 (¶47). Medical records and the pill-bottle labels confirm that the prescribed medication was countersigned to be dispensed that day, March 23, around noon. SA113 (¶52); SA180.

As instructed, Gil went to the evening medication line, expecting to receive his prescribed medication. SA112 (¶49). Defendant Penaflor was dispensing medication

that evening. *Id.*; SA389 (¶6). When it was Gil's turn to get his medication, Penaflor picked up two bottles of medicine, glanced at the labels, but gave only one bottle to Gil — the bottle containing Tylenol III. SA112 (¶49). When Gil asked about the Cephalexin, Penaflor refused to give it to him, angrily telling Gil that he could not have it. *Id*. Penaflor offered no explanation why not. *Id.* When Gil persisted, Penaflor threatened to place Gil into segregation housing if Gil did not leave. *Id.* Gil returned to his housing unit, where he explained to the duty officer, Officer Wilson, that Penaflor had refused to dispense the Cephalexin. SA112 (¶50). Officer Wilson called Penaflor. *Id.* Penaflor said that he was too busy to talk and abruptly hung up. *Id*. The next day, March 24, a different staff member, David Steiner, finally gave Gil his prescribed antibiotic. SA389 (¶7).

After Gil took the antibiotic, his incision felt better, which he reported to the medical staff the very next day, March 25. SA113 (¶54); SA182. Gil nevertheless required three medical appointments to lance and drain his infection. SA113 (¶53); SA181-SA182.

Despite the surgery, Gil's long-term condition failed to improve; over the next year, his rectal prolapse continued to plague him, and he developed two hernias (one umbilical, the other "in the incision area"). SA114 (¶56); SA116 (¶65); SA120 (¶84). As early as April 6, one month after the first surgery, the FCI-Oxford medical staff diagnosed a recurrence of Gil's rectal prolapse. SA114 (¶57); SA186. Gil was told to wait a year before undergoing another procedure, however, to let his body recover from the trauma from his recent surgery. SA16 (¶93).

A little more than a year later, on June 14, 1999, Gil met with Dr. Heise, an outside surgeon who consults with FCI-Oxford. SA116 (¶66). Dr. Heise told Gil that the prior rectal prolapse operation performed by Dr. McDonald was unsuccessful and diagnosed Gil with a recurrence of the prolapse. *Id.* Dr. Heise recommended that Gil obtain another opinion from a colorectal specialist about undergoing a second surgery to repair the prolapse. *Id*.

On August 4, 1999, Gil was able to meet with Dr. McDonald, who had performed the first surgery. SA117 (¶68). Dr. McDonald, however, is not a board-certified colorectal specialist. SA226; SA434 (¶47). Dr. McDonald advised Gil that the only option for the repair of his rectal prolapse was another attempt at the abdominal approach. SA117 (¶69); SA200. Dr. McDonald informed Gil that this approach carried the risk of nerve damage and subsequent inability to achieve an erection. SA117 (¶68); SA200.

After seeing Dr. McDonald, Gil repeatedly asked to obtain a medical opinion from a colorectal specialist. SA117-SA118 (¶¶70-74). Every request was denied. *Id.* On December 4, 1999, Dr. Heise again advised Gil that he should be permitted to see a specialized colorectal surgeon. SA118-SA119 (¶77); SA222. Dr. Heise told Gil, contrary to Dr. McDonald's advice, that there was a less invasive procedure available for repairing the rectal prolapse that would not cause further abdominal trauma. SA118-SA119 (¶77); SA222. The FCI-Oxford medical staff again refused Gil's request to obtain an opinion from a colorectal specialist. SA119 (¶78).

On December 15, the FCI-Oxford medical staff spoke with Dr. McDonald and explained Gil's reluctance to repair his prolapse abdominally and Gil's desire to see a

qualified colorectal specialist. SA226. Dr McDonald concurred: “he prefers the [patient] be seen by a board-certified colorectal surgeon” and recommended Dr. Michael Kim. *Id.*

Gil saw Dr. Kim on January 6, 2000. SA120 (¶85). To repair the prolapse, Dr. Kim recommended operating via the rectum, rather than another surgery through the abdomen (as Dr. McDonald had urged). SA120-SA121 (¶85). He also recommended a separate operation to repair Gil’s hernias. *Id.*

Following the meeting with Dr. Kim, Gil repeatedly requested that the surgery be performed. SA121-SA122 (¶¶86-91). No reason for the delay was provided. SA122 (¶91); SA225 (administrative report stating: “Now I have been waiting again to have an operation. What is the delay this time?”). The surgery was finally scheduled for May 1, 2000, more than two years after the rectal prolapse was witnessed and over ten months after Gil was told the surgery was necessary. SA122 (¶92). During this entire period, Gil had to push his rectum back into his body after each bowel movement, a painful process. SA116-SA117 (¶67); SA439 (¶11).

Dr. Kim performed the rectal prolapse surgery via the rectum on May 1. SA122 (¶92). Following the surgery, Dr. Kim recommended a sitz bath to decrease the swelling. SA449 (18:11-12). He also prescribed Vicodin, Milk of Magnesia, Metamucil and Colace. SA448-SA449 (15-17). Vicodin is a pain medication. SA448 (15:10). The other three medications are laxatives that perform different functions: Milk of Magnesia is used “in case [the patient does] not have a bowel movement for several days.” SA449 (17:8-9). Metamucil “bulk[s] up the stools so [patients don’t] get constipated or they don’t strain when they have to have their first bowel movement.” SA448 (16:22-24).

Colace is "a stool softener" whose "function is to soak up water so that the stool becomes [softer]." SA449 (17:22-24). For pain relief, Dr. Kim specifically prescribed Vicodin instead of Tylenol III because, in his experience, Vicodin caused less constipation than Tylenol III. SA450 (21:10-16). Dr. Kim specifically warned Gil not to take Tylenol III because of its tendency to cause constipation. SA122-SA123 (¶95); *see also* SA122 (¶93).

When Gil returned to FCI-Oxford, he gave his prescriptions to Dr. Reed to be filled. SA122-SA123 (¶95).[3] Dr. Reed, however, deviated from Dr. Kim's instructions. *Id.* Dr. Reed changed the prescription from Vicodin to Tylenol III, despite the fact that Gil told Dr. Reed that Dr. Kim specifically warned against that change. *Id.* In addition, Dr. Reed cancelled Dr. Kim's prescription for Metamucil and Milk of Magnesia despite the well-known risk that after surgery Gil would likely suffer from constipation. *Id.*; SA417; *see also* SA451 (28:1-3).

On May 5, Gil had an appointment with Dr. Reed at which he complained of pain and constipation because he had been unable to have a bowel movement since the operation. SA123 (¶96). Dr. Reed allowed Gil to receive Milk of Magnesia. *Id.*; SA417.

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[3] This was not Gil's first interaction with Dr. Reed: Following his first surgery, Gil sued Dr. Reed in *Gil v. Jones*, No. 99-C-0038-C (W.D. Wis.). SA124 (¶100); SA218. On June 15, 1999 — one day after Gil served Dr. Reed in that suit — Gil had an appointment with Dr. Reed at which Dr. Reed was openly hostile because "[Gil was] going to make [him] waste [his] time going to court." SA218. Later, on September 14, 1999, Dr. Reed made Gil wait in the lobby to see him for six and 1/2 hours after the scheduled time. SA219. When Dr. Reed finally saw Gil, Dr. Reed proceeded to berate Gil regarding the lawsuit, telling Gil "that [he] should not expect to come to him for medical assistance now that [he had] sued him." *Id.* In this suit, the district court ultimately granted summary judgment for defendants. *Gil v. Jones*, 2000 WL 34235979 (W.D. Wis. July 20, 2000).

The Milk of Magnesia, however, was not ready for Gil until May 8 — a week after it was first prescribed. SA123-SA124 (¶¶97-98).

On May 9, still unable to have a bowel movement, Gil scheduled an appointment with Dr. Reed. SA124 (¶99). Gil was in severe pain and was bleeding from the rectum. *Id*. Dr. Reed was not available at the scheduled time. *Id*. Gil waited for Dr. Reed for one hour and then advised the medical staff that he could not wait any longer and returned to his cell to address the bleeding and to lie down. *Id*. Medical staff examined Gil the next day and concluded that he was severely constipated and was unable to urinate. SA126 (¶104). Dr. Aslam, a prison physician, drained Gil's bladder with a catheter and gave him two enemas to treat the constipation. *Id*. Dr. Aslam also told Gil to stop taking Tylenol III immediately because of its constipating effects. *Id*.; SA257. Dr. Aslam prescribed Motrin instead. SA126 (¶104).

On May 11, Gil met with Dr. Kim for a post-surgery check up. SA126 (¶106). Gil mentioned his subsequent ills and the changes to his prescriptions. *Id.* Dr. Kim was upset that his instructions had been disregarded and rewrote his original prescriptions. *Id.*; SA449 (20:7-21). Dr. Kim again advised Gil against taking Tylenol III. SA127 (¶107). Nonetheless, when Gil returned to FCI-Oxford, Dr. Reed again prescribed Tylenol III, despite Dr. Kim's warning. *Id.* Dr. Reed also allowed Gil to receive Metamucil and Milk of Magnesia. SA260.

The next day, May 12, Gil was seen by Dr. Aslam. SA127 (¶108). Dr. Aslam advised Gil "to use Tylenol No. 3 sparingly because of its constipating effect" and prescribed Motrin instead. *Id.*; SA261.

On December 21, 2000, Gil filed a *pro se* complaint alleging several causes of action arising from the medical treatment provided by Penaflor, Dr. Reed, and others. SA1-SA103. The government moved for summary judgment primarily on the ground that Gil was required to offer expert medical testimony in support of his case but failed to do so. SA333. On January 28, 2002, the district court granted judgment in Defendants' favor. SA326-SA327.

Gil appealed the January 28 ruling as well as an earlier ruling that denied him the assistance of counsel to pursue his claims. SA334. On August 25, 2004, this Court held that the district court abused its discretion in denying Gil's request for assistance of counsel. SA340. This Court also held that Gil did not need to produce expert medical testimony to support his FTCA claims and that, where necessary, Gil could rely on testimony from his treating physicians to establish the standard of care. SA343-SA345. It further concluded that Gil had presented sufficient evidence to proceed to trial with his Eighth Amendment claim against Penaflor for Penaflor's refusal to provide the prescribed antibiotic for no reason. SA346-SA348. Finally, this Court held that Gil had demonstrated a genuine issue of material fact regarding whether Dr. Reed was deliberately indifferent to his serious medical needs. SA348-SA351.

On remand, the Defendants submitted an expert report by Dr. Jeffrey Harms (SA353-SA382) and the deposition testimony of Dr. Kim (SA444-SA473). Defendants again moved for summary judgment, arguing that, based on this new evidence, trial was unnecessary. On January 6, 2006, the district court again granted judgment in Defendants' favor. A30. In particular, it held that (i) Penaflor's actions were not

actionable because there was no proof that Gil had been injured by Penaflor's decision not to provide the prescribed antibiotic (A19); (ii) Gil failed to state an Eighth Amendment claim against Dr. Reed because the "factual record presently before the court [materially] differs from the record the court of appeals relied on" and revealed that Dr. Reed was not deliberately indifferent as a matter of law (A14); and (iii) Gil had failed to present sufficient evidence to support his FTCA claims (A23-A29). This appeal followed.

SUMMARY OF ARGUMENT

When this case was previously before this Court, the Court reviewed the record and concluded that Gil had presented sufficient evidence to proceed to a jury on his Eighth Amendment and FTCA claims. Since this Court's prior decision, no evidence has been withdrawn. In fact, the only change to the record is the addition of "new" evidence. This "new" evidence, however, does not eliminate already existing issues of material fact, which this Court previously held must be decided by a jury. Nor does the "new" evidence materially change the state of the record. Accordingly, it does not justify a departure from this Court's earlier decision. The district court held to the contrary only because it improperly (yet consistently) construed facts in the light most favorable to Defendants rather than to Gil, the non-movant.

1. This Court has already determined that evidence of Penaflor's angry refusal to give Gil an antibiotic for no legitimate reason following Gil's first rectal prolapse surgery, when Gil suffered from a golf-ball sized infection, satisfied the standard for presenting an Eighth Amendment and a FTCA claim. On remand, the lower court did

not challenge any of this Court's reasoning. It nonetheless entered summary judgment for Defendants, reasoning that Gil did not provide evidence that he was injured by Penaflor's angry denial merely because a different staff member ultimately gave Gil the antibiotic twelve hours later. The district court was wrong on both the facts and the law. The evidence clearly shows what common sense indicates *and this Court previously held*: denying an antibiotic to a patient with a golf-ball sized infection that required three sessions for lancing and draining injured that patient, and that injury is adequate to satisfy the "injury" requirement for both an Eighth Amendment and a FTCA claim. While a plaintiff must have a *serious medical need* (which Gil indisputably satisfies here) to state an Eighth Amendment claim, the law does not require that the resulting injury caused by the misconduct be severe. Gil's Eighth Amendment claim against Penaflor, and his FTCA claim based on the same conduct, should go to trial.

2. This Court has also already held that Gil is entitled to a jury trial on both his Eighth Amendment and FTCA claim involving Dr. Reed's decision, following Gil's second rectal prolapse surgery, to change Dr. Kim's prescriptions by cancelling two of the three prescribed laxatives and substituting Tylenol III for Vicodin, even though Dr. Kim had warned that Tylenol III was more constipating and should be avoided. The district court was wrong that new evidence compelled judgment in Dr. Reed's favor. Not only did the district court make numerous factual errors in holding that judgment for Dr. Reed was warranted, but it also improperly held that Dr. Kim's statement that Dr. Reed's conduct met the standard of care was dispositive of Gil's claims. Where, as here, there is evidence that Dr. Reed's conduct was motivated by animus against Gil

because Gil had previously sued him, a plaintiff may establish an Eighth Amendment violation even if the standard of care were met. In any event, there is evidence that the standard of care was not met here. Thus, Gil's Eighth Amendment claim against Reed, and his FTCA claim based on the same conduct, should also go to trial.

3. Gil has also presented sufficient evidence to proceed to trial on his remaining FTCA claims. In holding to the contrary, the district court erroneously applied Wisconsin evidentiary rules rather than the Federal Rules of Evidence, as this Court urged. The district court also erred by ignoring the fact that Gil alleged both medical malpractice *and* common-law negligence claims (based on FCI-Oxford's duty under 18 U.S.C. § 4042 to provide "for the safekeeping, care, and subsistence" of federal inmates). This is significant because expert testimony is *not* required to establish common-law negligence (unlike medical malpractice, for which expert testimony is sometimes required). Moreover, in holding that judgment was warranted in favor of the government, the lower court made several factual errors and improperly construed the evidence in the light most favorable to the government. This Court should reiterate what it previously held — that Gil should receive a trial on all of his claims.

STANDARD OF REVIEW

This Circuit reviews *de novo* a district court's grant of summary judgment. *Epps v. Creditnet, Inc.*, 320 F.3d 756, 758 (7th Cir. 2003). It must "construe the facts in a light most favorable to Diego Gil, the party opposing judgment, and * * * draw all reasonable inferences in his favor." SA329.

ARGUMENT

It has long been recognized that prisons owe their inmates a duty of care involving basic medical treatment because inmates are unable to obtain such treatment on their own. "An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or a lingering death * * *. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose." *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (citation and internal quotation marks omitted). Thus, prisons must not only refrain from injuring inmates, but they have "an affirmative obligation [under the Eighth Amendment] 'to provide persons in * * * custody with a medical care system that meets minimal standards of adequacy.'" *Benson v. Cady*, 761 F.2d 335, 339 (7th Cir. 1985) (quoting *Wellman v. Faulkner*, 715 F.2d 269, 271 (7th Cir. 1983)); *see also* 18 U.S.C. § 4042 (BOP has duty to provide "for the safekeeping, care, and subsistence" of federal inmates).

This Court has already held that there is sufficient evidence in the record to warrant trial on Gil's Eighth Amendment and FTCA claims regarding inadequate treatment of his rectal prolapse and subsequent recurrence — a condition that caused him severe pain, requiring him to push his rectum back into his body after every bowel movement. Nothing occurring since that decision changes this conclusion. No evidence has been withdrawn, and if Gil had presented sufficient evidence to proceed to trial then, he certainly has enough evidence to go to trial now. The government claims that

the "new" evidence changes everything. But it does not. While it may create new genuine issues of material fact, it does not eliminate existing genuine issues of material fact that this Court found previously. Indeed, in granting judgment to Defendants, the lower court consistently overread the "new" evidence and improperly viewed it in the light most favorable to Defendants — and not to Gil, the nonmovant.

Moreover, other bases the district court relied upon for granting summary judgment were expressly raised before this Court issued its prior decision and were either expressly or implicitly rejected by this Court. Thus, this Court should again reverse the district court's grant of summary judgment for Defendants.

I. Gil Is Entitled To A Trial Against Penaflor.

Nowhere is the district court's error in granting summary judgment more apparent than in its resolution of Gil's claims against Penaflor. The required *de novo* review, construing all facts in the light most favorable to *Gil* (*see supra* p. 14), makes clear that trial is required to resolve Gil's Eighth Amendment claim against Penaflor and Gil's FTCA claim based on that conduct.

A. Gil has a viable Eighth Amendment claim against Penaflor.

A prisoner alleging an Eighth Amendment violation for inadequate medical care must establish that "prison officials, acting with deliberate indifference, exposed [the] prisoner to a sufficiently substantial risk of serious damage to his future health." *Farmer v. Brennan*, 511 U.S. 825, 843 (1994) (citation and internal quotation marks omitted). This standard is met by showing that "(1) [the plaintiff's] medical condition was objectively serious, and (2) the state officials acted with deliberate indifference to his medical

needs, which is a subjective standard." *Sherrod v. Lingle*, 223 F.3d 605, 610 (7th Cir. 2000). Deliberate indifference may be "evidenced by either actual intent or reckless disregard." *Benson*, 761 F.2d at 339.

This Court has already thoroughly reviewed the evidence and determined that both elements of the standard were met here. First, this Court found that Gil had a serious medical need when Penaflor denied him the prescribed antibiotic. SA346; *cf.* SA347-SA348 ("Gil's need for the antibiotic to treat a serious infection involving a surgical wound was substantial."); *Zentmyer v. Kendall County, Ill.*, 220 F.3d 805, 810 (7th Cir. 2000) (if a physician diagnoses a medical condition as requiring treatment, that condition is objectively serious for the purpose of alleging an Eighth Amendment violation). Second, this Court also concluded that Penaflor acted with deliberate indifference to Gil's need: "Construing the facts in Gil's favor, Penaflor simply refused to provide a prescribed antibiotic to a person with a serious infection. His angry tone of voice at the time of the refusal could indicate that he had no legitimate reason for the refusal and may have been motivated by malice." SA345. As this Court further explained, "this was a deliberate and potentially malicious act. Again, the cost to Penaflor of meeting Gil's serious medical need was zero. In that context, a single incident may be enough to make out a claim for deliberate indifference." SA348.

The Court also addressed the lower court's claim (SA322) that Gil had presented no evidence of injury from the denial:

> Finally, as for Gil's injury, we need not check our common sense at the door. A delay in providing antibiotics will necessarily delay the curing of the infection or possibly lead to its spread. Gil presented testimony as to

> the pain caused by the infection, which required lancing and draining multiple times, and he also presented evidence that within 24 hours of taking the antibiotic he began to feel better. A jury could infer that Penaflor's delay caused Gil that many more hours of needless suffering for no reason. That is enough to survive summary judgment.

SA348.

The evidence supporting this Court's conclusions remains part of the record. The district court nevertheless reinstated summary judgment on remand, stating that, although this Court had found "that * * * plaintiff was harmed as a result of defendant Penaflor's actions, * * * the parties have introduced additional evidence [on remand] that would allow judgment to be entered in defendant Penaflor's favor." A17-A18. It explained:

> In light of Dr. Kim's opinion that Cephalexin has no pain killing effect and Dr. Harms's opinion that a twelve-hour delay in the delivery of an antibiotic would not significantly affect or delay the healing of the abscess, there is no basis for a finding that plaintiff suffered injury as a result of defendant Penaflor's actions. Plaintiff attempts to show injury by introducing Dr. Kim's testimony that delaying Cephalexin by twelve hours might have a negative effect on a patient who has a preexisting severe infection and is "really sick" and has to be hospitalized for treatment. Dr. Kim explicitly differentiated an outpatient being treated for an infected abscess with draining at office visits and oral antibiotics from a patient who has a preexisting severe soft tissue infection of a magnitude that requires hospitalization and intravenous antibiotics. There is no evidence that plaintiff's infection rose to the level of requiring hospitalization and intravenous antibiotic treatment. Plaintiff has not raised a genuine issue of material fact as to whether defendant Penaflor's failure to give him the Cephalexin at the evening medication line on March 23 caused him injury. Accordingly, summary judgment is warranted in defendant's favor.

A18-A19.

The district court's analysis is flawed in at least three critical respects. First, it completely ignores Gil's own testimony that he felt better after receiving the medication (SA113 (¶54)), as well as Gil's claim that the denial of the medication caused him physical discomfort, anxiety and fear (SA15 (¶89)). These are matters uniquely within his purview on which he is competent to testify. *See, e.g.*, *Walker v. Benjamin*, 293 F.3d 1030, 1040 (7th Cir. 2002) ("because pain is a uniquely subjective experience, a plaintiff need not produce objective evidence of injury in order to withstand summary judgment") (citing *Cooper v. Casey*, 97 F.3d 914, 917 (7th Cir. 1996)). This Court expressly held that Gil may rely on this evidence to establish the existence of his injury. SA348; *cf.* SA345 ("no expert testimony is needed" for Gil to establish his FTCA claim against Penaflor because "[i]t is within a layperson's purview to know that when a serious infection at the site of a surgical wound is diagnosed and an antibiotic is prescribed, failure to supply or delay in supplying the antibiotic can result in unnecessary pain, discomfort and a spreading of the infection").

Second, the court appears to have overread the "new" evidence, improperly viewing it in the light most favorable to the Defendants. In fact, the Harms report and Dr. Kim's deposition testimony indisputably did *not* negate the existence of injury from Penaflor's denial of the antibiotic. Rather, the evidence is much more nuanced and, if anything, confirms that a reasonable juror could find that Penaflor's refusal to give Gil the antibiotic caused Gil additional suffering for no legitimate reason.

Contrary to the district court's description, Dr. Kim did not testify that the delay in providing the antibiotic would have *no effect* on Gil's healing. In his deposition, Dr.

Kim said only that the delay would probably not have a "*significant* affect on the abscess treatment." SA453 (36:10-17) (emphasis added). He certainly did not say that the delay would not impact the healing process at all. Indeed, how could he? To do so, as this Court previously explained, would be to "check our common sense at the door," as "[a] delay in providing antibiotics will *necessarily* delay the curing of the infection or possibly lead to its spread" (SA348 (emphasis added)), which had happened in the previous five days as the infection grew to a size of a golf ball.

Indeed, while the lower court characterized Dr. Kim as saying that there would be no injury from the delay unless "plaintiff's infection rose to the level of requiring hospitalization and intravenous antibiotic treatment," that characterization takes Dr. Kim's testimony out of context. Dr. Kim was asked whether a twelve-hour delay would likely cause a "*severe*" infection. SA454-SA455 (40:25-41:1) (emphasis added). He responded:

> [I]f they already have a preexisting severe infection, then delaying it would make the difference, but when we put people on oral antibiotic, usually they're not that — they don't have that severe soft tissue infections where delaying twelve hours is — isn't going to make that much difference per se. I'm talking about somebody who is really sick and they have to be admitted, then delaying twelve hours probably would make a difference, but if they come into the office and lance it and then go home, * * * [a] twelve-hour delay probably wouldn't make any difference.

SA455 (41:2-14). Thus, Dr. Kim did not testify that Gil suffered no injury at all. To the contrary, he set forth a spectrum of injuries caused by the delay in providing Cephalexin, where the severity of the injury may depend on the degree of the existing infection. Dr. Kim was not saying that only inpatients get better from antibiotics; he

merely said that the injury to outpatients was not likely to be as severe. *Cf.* SA453 (36:16-17) ("A twelve-hour delay in antibiotic probably has very little outcome."). Indeed, it is important to note that Dr. Kim was asked about outpatients receiving one lancing and draining session, but Gil's infection was more severe, requiring *three* lancing and draining sessions.[4]

Dr. Harms's testimony was similarly qualified. He stated only that "[t]he failure to administer an antibiotic for a period of time did not cause *undo* problems." SA356 (emphasis added); SA383 (¶8) (same). Thus he, like Dr. Kim, did not say that Gil was not hurt by the needless 12-hour delay in receiving treatment. In fact, Dr. Harms acknowledged that doctors do not prescribe antibiotics for no reason, stating that it is his professional practice not to prescribe antibiotics "unless [his patients] have significant spreading of cellulitis." SA356. From this testimony alone, a reasonable juror could conclude that Gil was injured by the delay. Last, Dr. Harms's conclusion that the denial did not "affect treatment as evidenced in the eventual excellent outcome" (*id.*) does not address whether Gil was injured by Penaflor's conduct. As the Sixth Circuit has held, just because a plaintiff's wound heals does not mean that the plaintiff suffered no harm. *Boretti v. Wiscomb*, 930 F.2d 1150, 1154 (6th Cir. 1991). A reasonable juror could

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[4] Dr. Kim stated that the lancing of the abscess was almost certainly more responsible for Gil's reduction in pain than the Cephalexin. SA454 (39:25-40:1). But Gil testified that taking the antibiotic reduced his pain and a juror could credit Gil's testimony. *See supra* p. 19. In any event, courts have held that prolonged suffering for no reason also supports an Eighth Amendment violation even when there is no pain. *See, e.g.*, *Koehl v. Dalsheim*, 85 F.3d 86, 88 (2d Cir. 1996) (holding that even though consequences of denying prescribed eyeglasses "do not inevitably entail pain, they adequately meet the test of 'suffering' that *Gamble* recognized is inconsistent with 'contemporary standards of decency'").

find, among other things, that the delay caused Gil injury by contributing to the need for repeated lancing and draining sessions and delaying recovery.

Indeed, the case law is clear that Gil provided sufficient evidence of injury to proceed to trial. To establish an Eighth Amendment violation, the defendant must act with a sufficiently culpable state of mind, and *the medical need must be serious*. *Cooper*, 97 F.3d at 916 ("Deliberately to ignore a request for medical assistance has long been held to be a form of cruel and unusual punishment but this is provided that the illness or injury for which assistance is sought is sufficiently serious or painful to make the refusal of assistance uncivilized.") (citation omitted). The law, however, does not require that *the resulting injury be severe. See*, *e.g.*, *Parrish v. Johnson*, 800 F.2d 600, 610-11 (6th Cir. 1986) (holding that plaintiff who sat in feces for several hours because of intentional neglect of prison personnel had viable Eighth Amendment claim); *Cummings v. Roberts*, 628 F.2d 1065, 1068 (8th Cir. 1980) (denial of plaintiff's access to wheelchair for three days leading "to failure to properly clean his person" sufficed to state claim for deliberate indifference). It is enough that Gil suffered some injury as a result of conduct that had no legitimate penalogical purpose. *See Cooper*, 97 F.3d at 916-17.[5]

In fact, it is important to note that it was a *different physician assistant* who ultimately gave Gil the Cephalexin twelve hours later. Simply put, Penaflor chose to

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[5] *Walker v. Peters*, 233 F.3d 494 (7th Cir 2000), cited by the district court (at A18), is not to the contrary. *Walker* holds only that there must be some injury before a plaintiff can make out a claim for deliberate indifference. 233 F.3d at 502. Gil has clearly showed some injury here. In any event, *Walker* appears to be in tension with *Madison County Jail Inmates v. Thompson*, 773 F.2d 834, 844 (7th Cir. 1985), which held that plaintiffs may be able to recover nominal damages for Eighth Amendment violations even if they cannot prove "actual harm" from the misconduct.

ignore Gil's need, even though, as this Court previously observed, "the cost of handing over the prescribed antibiotic was zero. The drug had been prescribed and dispensed into a bottle labeled for Gil and was in Penaflor's hand when he refused to hand it over." SA347. This conduct is certainly below the "the civilized minimum of public concern for the health of prisoners" required by the Eighth Amendment (*Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir. 1999)) regardless of how much harm Gil ultimately suffered as a result of Penaflor's inexcusable conduct.[6]

B. Penaflor's actions also raise a viable FTCA claim.

Under the FTCA, the "United States shall be liable, respecting the provisions of this title relating to tort claims, in the same manner and to the same extent as a private individual under like circumstances." 28 U.S.C. § 2674. A claim brought under the FTCA is governed by the "law of the place where the act or omission occurred" (28 U.S.C. § 1346(b); *Campbell v. United States*, 904 F.2d 1188, 1191 (7th Cir. 1990)) — here, Wisconsin.

Gil has brought both a common-law negligence and a medical malpractice claim against Penaflor. Under Wisconsin law, both of these claims require a showing of four factors: "(1) a breach of (2) a duty owed (3) that results in (4) an injury or injuries, or damages." *Paul v. Skemp*, 625 N.W.2d 860, 865 (Wis. 2001). "To survive summary judgment, Gil need not prove his claim; he need only show that there is a genuine issue of material fact as to each of these elements." SA342.

[6] Indeed, Penaflor had nothing to do with the delay being only 12 hours; he *never* gave Gil the medicine. Hence, it would be improper to grant judgment for Penaflor based on the relatively short duration of the delay in receiving treatment.

That standard is easily satisfied here. As this Court previously explained: "No doubt any physician would testify that delaying antibiotics for a serious infection for no reason other than spite does not meet the standard of care for a physician's assistant." SA345. Thus, "[s]ummary judgment was not warranted" on Gil's FTCA claim. *Id.*

The district court nevertheless reinstituted judgment on this FTCA claim because it concluded that Gil was not injured by Penaflor's conduct. A26. As explained above (at 19-23), however, that holding was wrong because Gil did present sufficient evidence of injury. Gil is entitled to trial on this FTCA claim.

II. Gil Is Entitled To A Trial Against Dr. Reed.

The required *de novo* review (*see supra* p. 14) also shows that Gil is entitled to a trial against Dr. Reed. Again, the district court relied on improper bases and erroneously viewed the evidence in the light most favorable to Dr. Reed in granting judgment in his favor.

A. Gil has a viable Eighth Amendment claim against Dr. Reed.

Gil's Eighth Amendment claim against Dr. Reed is founded primarily on Dr. Reed's decision to change the prescriptions of Dr. Kim, a colorectal specialist, after Gil's second rectal prolapse surgery. As this Court summarized: "When Gil returned from the hospital after the second surgery for his rectal prolapse, a surgery that was performed through his rectum * * *, Dr. Kim sent explicit instructions to take a certain regimen of laxatives (Colace, Milk of Magnesia and Metamucil) and to not take Tylenol III because of its constipating effects." SA348. "Dr. Kim pr[e]scribed Vicodin instead, a drug that is not part of the Bureau of Prison's national formulary. Reed cancelled the

Milk of Magnesia and the Metamucil and substituted Tylenol III for the Vicodin. He did this after Gil passed on Dr. Kim's warnings about the dangers of constipation for Gil following rectal surgery." *Id.* Thus, this Court concluded, the record "demonstrates that Reed prescribed Tylenol III no fewer than three times after being warned about the dangers of this drug for persons suffering from rectal prolapse. Eventually, the prison medical staff substituted Motrin for Vicodin." *Id.*

Gil obviously had a serious medical need; he had just undergone rectal surgery. This Court also held that "Gil has presented sufficient facts to create a genuine issue as to Reed's state of mind in refusing to follow the specialist's advice [and whether he was deliberately indifferent]" because "prescribing on three occasions the very medication the specialist warned against because of its constipating effect (when a non-constipating alternative [Motrin] was available) while simultaneously cancelling * * * two of the three prescribed laxatives gives rise to a genuine issue of material fact about Reed's state of mind." SA350-SA351.

The evidence upon which this Court reached these conclusions remains part of this record. The district court nevertheless granted judgment to Dr. Reed because it believed that new evidence in the record removed any basis for "finding that defendant Reed was deliberately indifferent to plaintiff's serious medical needs when he altered plaintiff's post-operative care." A15. As it explained, new evidence indicated that Dr. Reed's conduct met the standard of care. A14. Moreover, it asserted, "[t]here are no facts in this expanded record suggesting that Dr. Kim provided an 'express warning' to defendant Reed that he was not to prescribe Tylenol III when plaintiff returned to the

prison after his surgery on May 1, 2000." A15. Based on this new evidence, in addition to its belief that Dr. Reed prescribed Milk of Magnesia and Metamucil once Gil failed to have a bowel movement for four days (*id.*), the district court held that there merely was a "'difference[] of opinion among medical personnel regarding a patient's appropriate treatment[, which does] not give rise to deliberate indifference.'" *Id.* (quoting *Estate of Cole v. Fromm*, 94 F.3d 254, 161 (7th Cir. 1996)).

The lower court's holding, however, is based on numerous factual and legal errors. For one, the lower court's analysis disregards the fact that the record still contains the evidence that this Court found sufficient to allow a reasonable juror to conclude that Dr. Reed acted with deliberate indifference to Gil's medical needs. In addition, the district court was simply wrong with respect to some of the evidence in the record. For example, Dr. Reed did not prescribe Milk of Magnesia and Metamucil after four days (as the district court thought); he only prescribed Milk of Magnesia on May 5. SA417.[7] Gil did not receive Metamucil for another week (when Dr. Kim rewrote the prescription). *Id.*; SA452 (30:6-14). Likewise, the district court's suggestion that there was no evidence of an "express warning" is, at best, highly misleading. As this Court recognized, there is evidence (SA122-SA123 (¶95)) that Dr. Kim expressly warned Gil not to take Tylenol III because of its tendency to cause constipation, which Gil later

[7] In Defendants' Additional Proposed Finding of Fact, they claimed that Dr. Reed prescribed both Metamucil and Milk of Magnesia on May 5 (SA430 (¶20)), which Gil mistakenly claimed was "undisputed" (SA432 (¶20)). On that same day, however, Gil also filed Plaintiff's Additional Proposed Findings of Fact, in which he properly stated that only Milk of Magnesia was prescribed at that time. SA435 (¶55). Defendants stated that this proposed finding was "undisputed" in their response. SA442-SA443 (¶55).

conveyed to Dr. Reed before Dr. Reed changed the prescription. SA348 ("[Reed substituted Tylenol III for Vicodin] after Gil passed on Dr. Kim's warnings about the dangers of constipation for Gil following rectal surgery"). It is immaterial whether the warning was conveyed directly by Dr. Kim to Dr. Reed or through Gil;[8] even if the warning were conveyed by Gil, it still would be powerful evidence that Dr. Reed was aware of the excessive risk posed by substituting Tylenol III for Vicodin, yet ignored that risk when prescribing Tylenol III anyway. *See* SA351; *cf. Vance v. Peters*, 97 F.3d 987, 993 (7th Cir. 1996) ("a prison official's knowledge of prison conditions learned from an inmate's communications can, under some circumstances, constitute sufficient knowledge of the conditions to require the officer to exercise his or her authority and to take the needed action to investigate and, if necessary, to rectify the offending condition") (citing *Antonelli v. Sheahan*, 81 F.3d 1422, 1428 (7th Cir. 1996)).[9]

The district court was also wrong on the law. While it was true that Dr. Kim testified conclusorily that Dr. Reed's post-operative treatment did not violate the standard of care,[10] this testimony does not require entry of judgment for Dr. Reed.

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[8] Dr. Kim did not deny that he may have warned Dr. Reed directly; Dr. Kim stated that he simply could not recall either way. SA449-SA450 (20:24-21:2).

[9] Contrary to the district court's implication, Dr. Kim did not deny that he told Gil not to take Tylenol III because of its constipating effects. To the contrary, Dr. Kim reiterated that Vicodin should be prescribed instead of Tylenol III and rewrote his original prescription when he saw Gil again on May 10. SA449-SA450 (20:20-21:15).

[10] SA450 (24:13-23):

> Q: At any time during the time that you were treating Mr. Gil did you consider the care that was provided to him by the medical staff at the prison was deficient in any way?
>
> A: No.

First, there can be an Eighth Amendment violation even if the standard of care is met. The Eighth Amendment is violated if an official is deliberately indifferent to a serious medical need. *See supra* p. 17. This is a *subjective* test, focusing on the official's motivation for his actions. *Id.* As this Court has recognized, proof of the standard of care is not necessary to establish a violation:

> Because the test for deliberate indifference is more closely akin to criminal law than to tort law, *the question of whether the prison officials displayed deliberate indifference toward [a plaintiff's] serious medical needs [does] not demand that the jury consider probing, complex questions concerning medical diagnosis and judgment. The test for deliberate indifference is not as involved as that for medical malpractice, an objective inquiry that delves into reasonable standards of medical care.*

Ledford v. Sullivan, 105 F.3d 354, 359 (7th Cir. 1997) (emphasis added). In fact, as the Second Circuit recognized in *Hathaway v. Coughlin*, 37 F.3d 63 (2d Cir. 1994), it is completely unnecessary for a plaintiff to introduce evidence regarding "whether [defendant's] conduct fell below professional norms," because "[t]he inquiry remains whether the treating physician or other prison official was deliberately indifferent to a prisoner's serious medical needs, not whether the doctor's conduct is actionable under state malpractice law." *Id.* at 68.

Durmer v. O'Carroll, 991 F.2d 64 (3d Cir. 1993), is instructive. In *Durmer*, a pre-incarceration accident and stroke left the plaintiff severely debilitated, needing physical

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Q: And do you have an opinion with respect to any of the decisions to change, alter or amend the postoperative care of Mr. Gil was anything substandard or did not meet the standard of care?

A: No, no. I was just unhappy, but that has nothing to do with standard of care.

therapy. *Id.* at 65-66. After incarceration, he did not receive the therapy the pre-incarceration physician has prescribed. *Id.* at 67-68. The plaintiff claimed that the lack of appropriate physical therapy evidenced deliberate indifference to his medical needs, because the State simply did not want to undergo the additional expense and burden. *Id.* at 68 & n.10. In response, the State set forth possible medical reasons why the plaintiff did not need more physical therapy. *Id.* at 68 & nn.8-9. The Third Circuit held that, even though the defendant doctor may have been able to show that his actions were medically proper, the evidence was sufficient for a jury to conclude that that the plaintiff's treatment was chosen for non-medical reasons and thus was deliberately indifferent to the plaintiff's medical needs. *Id*. at 68 (stating that defendant doctor "might have had a motive for deliberately avoiding physical therapy" based on burden and expense of care). It was the jury's role to determine the reason for denying treatment.

That is precisely the situation here. There is direct evidence in the record that Dr. Reed changed Dr. Kim's prescription not as a simple exercise of medical judgment, but rather because Dr. Reed was motivated by animus against Gil because Gil had sued him previously. SA124 (¶100). For instance, on June 15, 1999 — just one day after Gil served Dr. Reed in that lawsuit — Dr. Reed was openly hostile to Gil during a medical appointment, complaining that "[Gil was] going to make [him] waste [his] time going to court." SA218. A few months later, on September 14, Dr. Reed made Gil wait six and 1/2 hours for an appointment. SA219. When Dr. Reed finally saw Gil, Dr. Reed proceeded to berate him regarding the lawsuit, telling Gil "that [he] should not expect

to come to him for medical assistance now that [he had] sued him." *Id.* Based on this evidence, a jury could reasonably conclude that Dr. Reed changed Gil's medications because Dr. Reed wanted to hurt Gil. It is telling that every change Dr. Reed made to the specialist's prescriptions increased the likelihood that Gil would become constipated — a painful condition given his recent rectal surgery.

To be sure, there may be circumstances in which the standard of care is relevant to an Eighth Amendment claim. For example, a series of negligent acts may rise to the level of deliberate indifference. *See, e.g.*, *Wellman*, 715 F.2d at 272. Similarly, the standard of care may help reveal when a disregarded risk is sufficiently substantial as to be reckless. *See Benson*, 761 F.2d at 339; *Fromm*, 94 F.3d at 261-62. But whether a doctor has violated the standard of care — a minimum professional threshold — is not a relevant inquiry when the doctor's choice of a more harmful or riskier treatment was motivated by actual bad intent, as Gil has alleged here. In such circumstances, *any* pain and suffering Dr. Reed intentionally caused is a form of cruel and unusual punishment proscribed by the Eighth Amendment. *See Durmer*, 991 F.2d at 69 ("if the failure to provide adequate [physical therapy] was deliberate, and motivated by non-medical factors, then [plaintiff] has a viable claim"); *cf. Enmund v. Florida*, 458 U.S. 782, 798 (1982) (intentional harm is more egregious than unintentional harm).

Second, even if Gil needed to show a violation of the standard of care to recover for an Eighth Amendment violation, Dr. Kim's testimony would support such a finding. A jury would be free to disregard his conclusion that the standard of care was met, and rely instead on the remainder of the evidence in the record about specific deficiencies in

Dr. Reed's treatment. *See Chambers v. Ingram*, 858 F.2d 351, 359-60 (7th Cir. 1988) (violation of standard of care is question of fact for the jury); *cf. Dodge v. Stine*, 739 F.2d 1279, 1284 (7th Cir. 1984) ("[expert] opinion evidence is not binding on the fact-finder even if no contradictory evidence is offered by the other side"). *See generally United States v. Douglas*, 408 F.3d 922, 926 (7th Cir. 2005) ("[w]here appropriate, a party is free to impeach the credibility of his own witness") (citing Fed. R. Evid. 607).

Dr. Kim identified several specific deficiencies in Gil's post-operative treatment. For instance, Dr. Kim stated that, if a patient like Gil must be given a constipating pain medication, he should be given other medications to address the constipation. SA451-SA452 (28:20-29:5). Yet Dr. Reed cancelled the Milk of Magnesia and Metamucil prescriptions when he changed Gil's prescription from Vicodin to Tylenol III (which was more constipating). Dr. Reed claimed that he refused to give these laxatives because he feared "severe dehydration" (SA386 (¶6)), but Dr. Kim refuted that claim, testifying instead that Milk of Magnesia and Metamucil "shouldn't cause dehydration." SA452 (29:16-30:1); *cf.* SA448 (15:8-10) (Vicodin and Metamucil were the "standard" post-operative treatment). Dr. Kim also testified that he was upset when he found out that Dr. Reed changed Gil's medications, and rewrote his original prescriptions when he saw Gil on May 10. SA449 (20:7-21).[11] As this Court previously concluded, "Dr.

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[11] Dr. Kim stated that, while Vicodin and Tylenol III are interchangeable for pain-management purposes, in his experience Tylenol III was more constipating. SA451 (27:11-21); *see also* SA450 (21:11-13) ("Tylenol #3 tend[s] to give more constipations [sic] than Vicodin, and it's one of the reason[s] I don't use Tylenol #3"). He also stated that Motrin may or may not be an appropriate substitute, depending on the level of pain that the patient is experiencing. *See* SA453 (34:25-35:8) ("[It d]epend[s] on the severity of the pain, but if the pain is manageable with Motrin and they're having constipations [sic], then I guess Motrin is better than continuing with the

Kim's angry reaction and reassertion of his earlier instructions are enough to create a genuine issue on whether Reed and Penaflor were meeting the standard of care required under the law." SA345.

Dr. Kim also testified that a patient complaining of constipation after colorectal prolapse surgery should have an enema administered within four to five days if the patient had not yet had a bowel movement. SA453 (33:11-22). Dr. Reed saw Gil on May 5, four days after the surgery. SA123 (¶96). Dr. Reed knew at that point that Gil was constipated and wrote about it in his notes. *Id.*; SA249. Dr. Reed failed to see Gil at Gil's May 9 appointment (*see supra* p. 10); hence, it was over nine days after Gil's surgery before Gil could get an enema, a delay that Dr. Kim stated was excessive. SA453 (33:11-17) ("For the enema [following rectal prolapse surgery], I would say, four, five days * * *. Definitely within a week they should do something.").

Thus, while Dr. Kim testified conclusorily that the standard of care was met, the jury could disregard that ultimate legal judgment and rely instead on the underlying facts to reach its own decision. *See Chambers*, 858 F.2d at 359-60; *Dodge*, 739 F.2d at 1284;

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narcotics or pain medications that has a constipating side effects. [However, he would not use Motrin instead of Tylenol #3 if the pain was more severe.]"). While this evidence does bear on Dr. Reed's choice of Tylenol III, "[Dr. Reed's] explanation is [still] suspect in light of the fact that prison medical personnel eventually prescribed non-constipating Motrin for Gil, demonstrating that Reed in fact had other options available to him that would have avoided the constipation. And in light of his acknowledgment that Tylenol III is constipating, it is [still] even more curious that he simultaneously cancelled two of the three prescribed laxatives." SA350. Moreover, as this Court noted, Dr. Reed should not be allowed to hide behind deficiencies in the prison formulary. SA349 n.3 ("We are troubled by Reed's attempt to justify prescribing an admittedly inappropriate drug because the appropriate drug was not a part of the Bureau of Prison's formulary."); *cf. Wellman*, 715 F.2d at 273 (holding that failure to staff psychiatric position because of low salary offering is not defense to Eighth Amendment claim).

Douglas, 408 F.3d at 926. As this Court stated previously: "Reed may be able to show at trial that his decisions were simply an exercise of medical judgment rather than deliberate indifference. * * * [But] Gil has demonstrated a genuine issue of material fact regarding whether Reed was deliberately indifferent to his serious medical needs [as to suffice at the summary judgment stage, where all inferences are construed in Gil's favor]." SA351.

To hold otherwise — that Dr. Reed's conduct evinced only "a difference of medical opinion" — would immunize all sorts of physician misbehavior from constitutional scrutiny. Merely because a defendant is a doctor does not give him or her carte blanche to change a specialist's prescription however the doctor wants. *See Estelle*, 429 U.S. at 104 n.10 (a doctor's choice of "'easier and less efficacious'" treatment can state claim for deliberate indifference) (citing *Williams v. Vincent*, 508 F.2d 541, 544 (2d Cir. 1974)). Such a result would effectively remove the state's "affirmative obligation" to prove adequate medical care to prisoners. *Benson*, 761 F.2d at 339.

To be sure, there may be some circumstances where the "medical judgment" defense may be appropriate even at the summary judgment stage, such as where another doctor questions the physician's decision after the fact (*e.g.*, *Fromm*, 94 F.3d at 261), a doctor chooses between competing medical diagnoses offered by other doctors (*e.g.*, *Norfleet v. Webster*, 439 F.3d 392, 396 (7th Cir. 2006)), or an inmate simply claims that the doctor's decision was wrong (*e.g.*, *Snipes v. Detella*, 95 F.3d 586, 591 (7th Cir. 1996)). But to our knowledge, the medical judgment defense has never been applied where a generalist doctor explicitly ignores a specialist's instructions, where there is

evidence that the doctor was motivated by malice, or where there is evidence that the "medical judgment" aggravated the very (warned-about) condition it was supposed to address. To the contrary, this Court has expressly held in *Jones v. Simek*, 193 F.3d 485 (7th Cir. 1999), that a doctor's choice to ignore a specialist's direction is evidence of deliberate indifference sufficient to allow a plaintiff to defeat summary judgment for defendant (*id.* at 490), and relied on *Jones* in concluding that "summary judgment should not have been granted in favor of Reed here." SA350; *cf. Benjamin,* 293 F.3d at 1040 (validity of prison doctor's stated explanation for refusing to dispense narcotic pain reliever prescribed by outside physician was question for trial). In stark contrast to Dr. Kim's expertise, there is no evidence that Dr. Reed has ever performed a rectal prolapse surgery, or that Dr. Reed has equivalent expertise to Dr. Kim with respect to what medications should be prescribed following such surgery. In light of this record, it is up to a jury to decide whether Dr. Reed changed Gil's medications because he merely had a "difference of medical opinion" or whether his conduct was the product of more base, and actionable, motives.

B. Dr. Reed's conduct also raises a viable FTCA claim.

This Court also previously held that Gil had set forth sufficient evidence to go to trial on his FTCA claim based on Reed's conduct. SA16-SA18. On remand, the district court nevertheless held that "summary judgment is warranted in defendant's favor" due to "Dr. Kim's and Dr. Harms's opinions that plaintiff's post-operative care [by Reed] was not inappropriate." A28. That holding is wrong: As explained above (at 31-

33), there is evidence in the record that Dr. Reed's post-operative treatment violated the standard of care. Gil thus should be allowed to proceed to trial on this claim too.[12]

III. Gil Is Entitled To A Trial On His Remaining FTCA Claims.

Gil has also alleged that several other acts constitute common-law negligence and/or medical malpractice for which he could recover under the FTCA. These acts can be broken into approximately three periods — (i) shortly after his first rectal prolapse surgery (March 19, 1998 - March 23, 1998); (ii) in the next two years, when Gil had to wait to see a second colorectal specialist and receive a second rectal prolapse surgery to remedy the recurrence of his condition; and (iii) following his second surgery in May 2000. In particular, the acts are:

- The unavailability of medical care at 11:30 pm on March 19, 1998;
- Physician assistant Kedrow's failure to treat Gil's infection the next day, giving Gil a pamphlet regarding back exercises instead;
- Gil's inability to see a doctor on March 21 and March 22;
- Penaflor's refusal to give Gil his antibiotic on March 23;
- Gil's inability to see a board-certified colorectal specialist regarding a second rectal prolapse surgery until January 2000;

[12] In *Massey v. United States*, 312 F.3d 272 (7th Cir. 2002), this Court held that there was no proof that a prison doctor's substitution of Tylenol III for Vicodin following a hernia surgery was negligent. *Id.* at 280. *Massey*, however, is easily distinguishable: In that case, unlike here, the inmate did not recently have surgery via the rectum; thus, the constipating side effects of the substitution were far less problematic than here. Also, there is no indication in *Massey* that the prison doctor cancelled prescribed laxatives.

- Gil's inability to get the second surgery until May 1, 2000, despite it being recommended as early as June 1999;
- Dr. Reed's alteration of Dr. Kim's prescriptions following the May 1 surgery;
- Dr. Reed's making Gil wait an hour for an appointment on May 9, despite the fact that Gil was severely bleeding; and
- Gil's inability to receive an enema to treat his constipation until May 10, nine days after surgery.

In its original opinion, the district court granted summary judgment on these claims because (i) Wisconsin law — the substantive law governing Gil's FTCA claims (*see supra* p. 23) — requires expert testimony to establish medical negligence except "'in [*res ipsa loquitur*] situations where [a physician's] errors were of such a nature that a layperson could conclude from common experience that such mistakes do not happen if the physician had exercised proper skill and care" (SA316) (quoting *Richards v. Mendivil*, 548 N.W.2d 85, 89 (Wis. Ct. App. 1996)); and (ii) Gil introduced no expert evidence of his own, seeking to rely instead on Defendants' expert evidence (SA317-SA318).

This Court reversed. It explained that:

> [W]e are doubtful that Wisconsin's expertise rule need be applied in federal court where the Federal Rules of Evidence apply exclusively. *See Ueland v. United States*, 291 F.3d 993, 998 (7th Cir. 2002). In federal court, no expert testimony is needed when the symptoms exhibited by the plaintiff are not beyond a layperson's grasp. *Ledford v. Sullivan*, 105 F.3d 354, 360 (7th Cir. 1997) (no expert needed in deliberate indifference case where plaintiff experienced nausea, dizziness, vomiting, a crawling sensation on his skin, emotional and mental regression, and depression when the defendants deprived him of his medication).

SA343. "Nonetheless," this Court stated, it was unnecessary to reach the issue of whether federal or Wisconsin evidentiary law applied, because "[e]ven under Wisconsin's evidentiary expertise rule, Gil's FTCA claims should survive summary judgment." *Id.* As this Court explained, expert evidence was not required on all of Gil's FTCA claims; where it was required, "Gil may rely on his treating physicians to establish the standard of care, even if those physicians are defendants or agents of defendants." SA345.

On remand, the district court granted judgment on all the FTCA claims again. The court held that the Wisconsin expertise rule applied to all of Gil's FTCA claims:

> Without express direction from the court of appeals to do otherwise, I will apply the Wisconsin expertise rule to each of plaintiff's negligence claims to determine whether in each instance plaintiff has shown that there is a genuine issue of material fact about the propriety of defendant's actions. In each instance, plaintiff will either have to show that the doctrine of res ipsa loquitur applies because a layperson would be able "to say as a matter of common knowledge that the consequences of the professional treatment are not those which ordinarily result if due care is exercised," or provide expert medical testimony suggesting that the standard of care was not met.

A22 (citation omitted).[13] It held that Gil's claims failed because the expert testimony did not establish negligence and the doctrine of *res ipsa loquitur* did not otherwise apply. A23-A29.

The lower court's decision is wrong both procedurally and substantively. In particular, the court should have applied the Federal Rules of Evidence to Gil's FTCA

[13] The district court noted that the choice of rules did not matter because "the federal expertise rule articulated by the court of appeals appears to be identical to the Wisconsin doctrine of res ipsa loquitur." A22.

claims — not Wisconsin evidentiary rules. In addition, Gil did introduce sufficient evidence of common-law negligence and/or medical malpractice. The district court reached the opposite conclusion only because it consistently construed all factual disputes against Gil, instead of in his favor, as is required at this procedural stage. *See supra* p. 14. This Court reviews *de novo* these lower court rulings. *Id.*

A. The Federal Rules of Evidence, and not Wisconsin evidentiary rules, apply to Gil's FTCA Claims.

As this Court noted, in federal court, "the Federal Rules of Evidence apply exclusively." SA343 (citing *Ueland*, 291 F.3d at 998). The district court inexplicably failed to distinguish *Ueland* or discuss why it does not apply. Though we note that some Seventh Circuit medical malpractice decisions have applied state evidentiary law (*e.g.*, *Keller v. United States*, 58 F.3d 1194, 1197 (7th Cir. 1995)), we submit that *Ueland* should control, and thus this Court should apply the Federal Rules of Evidence. *Cf. Rolick v. Collins Pine Co.*, 975 F.2d 1009, 1013 (3d Cir. 1992) ("Since the question involves the admission of evidence in a federal court, the Federal Rules of Evidence control.").

In addition, Gil has not just raised medical malpractice claims. He has also alleged common-law negligence. A20. Under Wisconsin law, a prisoner may state a negligence claim against a prison employee (even if malpractice is not committed) if he alleges "an unreasonable delay in obtaining medical assistance" that caused him to "sustain a serious illness or injury." *Brownelli v. McCaughtry*, 514 N.W.2d 48, 50-51 (Wis. Ct. App. 1994). The basis for such a negligence action is prison employees' duty to protect inmates in their custody from harm. *Id.* at 50; *see also* 18 U.S.C. § 4042 (BOP has a

duty to provide "for the safekeeping, care, and subsistence" of federal inmates). Expert testimony is not required to prevail on this type of claim. *See Brownelli*, 514 N.W.2d at 50-51 (looking to affidavits to determine whether a triable issue of fact existed, not expert testimony); *see also* SA7.

Hence, even if Wisconsin evidentiary rules apply, Gil need not introduce expert evidence to prove his common-law negligence claims. *Cf. Keri v. Board of Trustees of Purdue Univ.*, 2006 WL 2338023, at *6 (7th Cir. Aug. 14, 2006) ("quintessential [Federal Rule of Evidence] 701 testimony include[s] * * * the mental state or responsibility of another") (citation and internal quotation marks omitted); *United States v. Fowler*, 932 F.2d 306, 312 (4th Cir. 1991) (Federal Rule of Evidence 701 allows a lay witness to testify to negligence).

B. Gil has presented sufficient evidence of medical malpractice and common-law negligence.

Even if Wisconsin evidentiary rules apply, Gil submitted sufficient evidence to go to trial on his FTCA claims.

1. Gil's first set of claims arises from the BOP's failure, for more than five days, to provide effective care for the infection setting in after Gil's first prolapse surgery. These claims sound in medical malpractice and common-law negligence based on FCI-Oxford's duty under 18 U.S.C. § 4042 to provide Gil with "safekeeping, care, and subsistence." As discussed in greater detail above (at 4-6), during those five days, Gil's infection developed into a golf-ball sized bulge, ultimately requiring repeated lancing and draining, aided by antibiotic and pain medication.

i. Denial of medical care on 3/19/98. As discussed above (at 4), Gil sought medical care at 11:30 pm on March 19, 1998, because of severe pain around his recent surgical incision, but he was unable to see medical personnel because FCI-Oxford did not provide 24-hour medical care. Thus, while a prison officer requested emergency medical care for Gil, none was available.

The district court dismissed this claim because "[a] prison's failure to staff prison doctors around the clock is not an obviously negligent act. Presumably, if an inmate presented a medical emergency when there were no prison doctors on duty, the inmate would be sent to an outside hospital." A23. "[S]ummary judgment is warranted in defendant's favor," it stated, because Gil introduced no expert testimony "to show that the prison health officials' actions failed to meet the required standard of care" and "adduced no evidence from which a layperson could conclude that the pain he was experiencing amounted to a medical emergency that warranted the immediate medical attention of a prison doctor or an outside hospital." *Id.*

The district court's analysis is doubly flawed. First, Gil's common-law negligence claim does not require expert testimony. *See supra* p. 39. Second, a reasonable juror could conclude that a medical emergency did exist based on Gil's testimony about the severity of the pain at the site of his incision and the fact that a prison officer had tried to obtain emergency medical care for Gil. It was simply wrong, at this stage of the proceedings, for the lower court to resolve all those factual issues against Gil. Indeed, a jury could clearly find that the prison officials were negligent because the risk of injury to Gil from not getting any care outweighed the cost of obtaining treatment. *Cf. Mesman*

v. Crane Pro Servs., 409 F.3d 846, 849 (7th Cir. 2005) (in a negligence case "the risk of injury has to be weighed against the cost of averting it").

ii. Kedrow's failure to treat Gil's infection on 3/20/98, giving him a back-exercise brochure instead. The next day, Gil detected a bulge at the site of his incision and sought medical care from Physician Assistant Kedrow. Gil told Kedrow that he was in severe pain and showed Kedrow the bulge at the incision. Kedrow, however, "was dismissive and curt" to Gil and gave him a brochure on how to perform back exercises. *See supra* pp. 4-5. Gil then complained to Lieutenant Turvey about his condition, but Turvey refused to obtain care for Gil. *Id.*

The district court held that this claim failed because Gil did not set forth expert testimony that Kedrow's conduct fell below the appropriate standard of care and did not show that *res ipsa loquitur* applied: "[P]laintiff has not produced any evidence suggesting that his wound was openly draining pus or that the area of the incision was red and hot or that the bulge was so large that it could not have been mistaken for ordinary swelling in the area of an incision, or that Kedrow knew plaintiff was suffering from a fever so high that a layperson would know Kedrow's response was inappropriate." A24. "It is true[,]" the court admitted, "that three days [later], prison medical staff diagnosed plaintiff with an infection at the site of his incision that needed to be drained and medicated, but this fact does not help plaintiff. Taking as true that by March 23 the bulge had grown to the size of a golf ball, *it does not follow automatically* that the symptoms plaintiff displayed three days earlier, on March 20, were such that a

layperson would conclude that Kedrow was obviously wrong in not taking immediate action." A25 (emphasis added).

The district court's own language portrays its mistake. At this stage in the proceeding, it is not necessary for Gil to establish conclusively, and "automatically," that he is entitled to prevail on these facts. That determination is for a jury to make. Thus, even applying the doctrine of *res ipsa loquitur*, the issue is not whether a "layperson *would* conclude" that Kedrow's response was negligent, but rather whether a layperson *could reasonably* conclude that it was. In addition, the district court ignored the fact that Kedrow knew that weekend care was not available when refusing to investigate Gil's pain further and that, as a result of Kedrow's conduct, Gil would not receive any treatment for three days. SA111 (¶46). Gil spent the weekend "in his cell, with chills and a fever and in significant pain." A25.[14] These facts and circumstances easily make out a case for negligence under the doctrine of *res ipsa loquitur* (*Richards*, 548 N.W.2d at 89), and thus Gil is entitled to trial on this claim even in the absence of expert testimony on the point.[15]

iii. Penaflor's angry refusal to give the antibiotic on 3/23/98. As discussed above (at 5-6, 17-24), Penaflor refused to give Gil his antibiotic. Penaflor's refusal to provide the antibiotic meant that Gil was unable to receive proper treatment for his infection —

[14] Thus, while the district court may be correct that the lack of weekend care is not independently actionable because Gil does not appear to have sought additional medical care over the weekend (A25), it is an important fact in assessing Kedrow's and Turvey's behavior.

[15] Expert testimony is not required under the Federal Rules of Evidence either because "the symptoms exhibited by [Gil] are not beyond a layperson's grasp." SA343.

by then, the size of a golf ball — for a fifth day. Gil is entitled to trial on this claim too because a jury could easily find that Penaflor breached his duty to provide adequate medical care (*Benson*, 761 F.2d at 339) and to provide Gil with "safekeeping, care, and subsistence" (18 U.S.C. § 4042) by denying Gil his needed medication and extending Gil's pain and suffering, even though "the cost of handing over the prescribed antibiotic was zero" (SA347).[16]

2. The second set of claims arises from FCI-Oxford's failure to provide Gil with adequate treatment for the recurrence of his rectal prolapse following the first surgery. Gil had to wait almost eleven months for a second rectal prolapse surgery after Dr. Heise recommended it.

i. Gil's inability to see a colorectal specialist until January 2000. As discussed above at (7-8), FCI-Oxford did not allow Gil to see a colorectal specialist, Dr. Kim, until January 2000, even though such an appointment had been recommended by an outside surgeon, Dr. Heise, more than six months before. During that time, Gil was able to see only Dr. McDonald, the surgeon who performed Gil's first unsuccessful surgery, but who is *not* a colorectal specialist.[17] Dr. McDonald wanted to proceed with another

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[16] The negligence in treating Gil's infection at the site of his incision also may have contributed to the development of a "relatively large ventral hernia" "in the incision area." SA116 (¶65).

[17] Dr. McDonald is board certified in general surgery and thoracic surgery but not colorectal surgery. *See* American Medical Association, DIRECTORY OF PHYSICIANS IN THE UNITED STATES, Entry for Dr. Robert Scott McDonald, Oshkosh, Wisconsin, at 8504 (39th ed. 2005) (SA474-SA478); SA226 (telephone call in which "Dr. McDonald states [to Dr. Reed] that he prefers the patient to be seen by a board-certified colorectal surgeon," Dr. Kim). This Court may take judicial notice of Dr. McDonald's qualifications. *See* Fed. R. Evid. 201(b)(2), (f); *cf.* SA330 n.1 (taking judicial notice of the different types of rectal prolapse).

abdominal approach, which posed the risk of further abdominal trauma and impotence. Dr. Kim rejected that approach and instead recommended surgery via the rectum, which would avoid those risks. Throughout this entire period, Gil suffered from severe pain and had to push his rectum back into his body after every bowel movement. [18]

The district court rejected Gil's claim based on this conduct. The lower court mistakenly characterized Gil's claim as being FCI-Oxford's failure to allow him "to see a *second* colorectal specialist between August and December 1999." A26 (emphasis added).[19] The court explained:

> Despite plaintiff's assertions that between August and December 1999 his rectum came out with each bowel movement and he experienced great pain in pushing his rectum back inside his body, Dr. Aslam noted during a November 19, 1999 appointment that plaintiff did not complain of pain or bleeding. Even assuming that plaintiff experienced pain throughout this period, it does not follow that the medical staff was negligent in not procuring plaintiff a second opinion prior to December 1999.

A27. Gil's claim failed, the court explained, because he did not introduce expert testimony that this delay was negligent or prove that the doctrine of *res ipsa loquitur* applied to a "four-month delay in arranging an appointment [for a second opinion]." A27.

Once again, the district court erred in resolving this claim against Gil. At the outset, it mischaracterized the evidence: Gil sought to see *a* board-certified colorectal

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[18] The hernia that developed at the incision area following Gil's first operation also caused him pain. SA120 (¶84); *cf. supra* note 16.

[19] The district court appeared to assume incorrectly that Dr. McDonald was a board-certified colorectal specialist like Dr. Kim. *See supra* note 17.

specialist for the first time; he had not been able to see a colorectal specialist before. Moreover, the delay was over five months, not four. The district court also erred by ignoring the procedural posture of the case. As it did previously, the court improperly resolved factual conflicts against Gil, including evidence regarding the extent to which Gil was in pain. Finally, the court erred by holding that Gil was required to offer expert testimony to support this claim. The case law is clear that if the plaintiff "requires nonmedical, administrative, ministerial or routine care, the standard of care need not be established by expert testimony." *Kujawski v. Arbor View Health Care Ctr.*, 407 N.W.2d 249, 252 (Wis. 1987). That is precisely what Gil claims here; a failure to arrange an appointment with a specialist is a paradigmatic administrative task. *Cf. id.* at 253 ("use or non-use" of restraint is a matter of routine care not involving "a situation so complex or technical that a jury would need expert testimony to determine the appropriate standard of care").

ii. Gil's failure to get a second rectal prolapse surgery until 5/01/00. Even after Dr. Kim recommended surgery in January 2000, FCI-Oxford waited until May 2000 — five more months — before Gil could have his second surgery. *See supra* p. 8. The district court was dismissive of this claim, stating that "it is commonplace for patients to wait several months before surgery can be scheduled." A28. As it explained, "[a]ccording to Dr. Kim, the only urgency in correcting a rectal prolapse would be to alleviate the patient's pain. *Although plaintiff contends that he was in pain during the four months while he waited for his surgery,* Dr. Kim did not testify that defendant was

negligent in keeping plaintiff waiting for four months for his scheduled surgery date." *Id.* (emphasis added).[20]

The district court's reasoning is remarkable. Dr. Kim testified that a rectal prolapse surgery is urgent if the patient is in pain. Gil testified that he was in pain while he waited for the operation. That should have been enough to allow Gil to present his claim to a jury.

There is more. Dr. Kim also testified that, while he does not worry about not getting the surgery "next week" or "next month," five months is more problematic because "it will probably get uncomfortable" "[i]f [the rectum] pops out." SA452-SA453 (32:17-33:10). He also stated that "sooner" is better than later "if they have symptoms [like the rectum popping out]." SA453 (34:14-16). It is undisputed that Gil's rectum was popping out. Dr. Kim himself witnessed it. SA456. Dr. Aslam witnessed this as early as April 1998. SA114 (¶57); SA186. A reasonable jury could credit Dr. Kim's testimony and conclude that, in light of these facts, it was negligent, and below the standard of care, to wait so long before getting the operation for Gil.

3. Gil's final claims center around the failure of the FCI-Oxford medical staff to treat Gil properly following his second rectal prolapse surgery on May 1. As discussed above (at 9-11, 24-35), that was when Dr. Reed changed Dr. Kim's prescriptions in a manner that aggravated Gil's constipation. Gil's other claims are as follows.

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[20] Though the district court called it a "four-month" delay, the real wait was eleven months because Dr. Heise had recommended a second surgery in June 1999.

i. Gil's hour wait to see Dr. Reed on 5/09/00, while he was bleeding from his rectum. On May 9, Gil had an appointment with Dr. Reed, for which Dr. Reed did not show up at the scheduled time. Although Gil was in severe pain and bleeding from his rectum, Gil waited an hour for Dr. Reed before returning to his cell to treat the bleeding. *See supra* p. 10.

The district court rejected this claim, reasoning that "[k]eeping a patient in the waiting area for an hour is commonplace in medical offices * * *. I could draw a different conclusion if plaintiff had adduced evidence that during his hour-long wait he communicated to the medical staff that he was bleeding and was in severe pain and that there was something the medical staff could have done to alleviate these symptoms [but] [p]laintiff has adduced no such evidence." A29.

Again, the district court construed the evidence against Gil. As the prison log book confirms, there is no dispute that Gil was actually bleeding. SA252. Gil also stated he was in severe pain. SA124 (¶99). Because of the pain, Gil stated that he "advised medical staff that [he] could not wait any longer" and returned to his cell "despite the possibility of being written for an infraction." *Id.* What symptoms Gil exhibited and how pressing treatment was is exactly the sort of factual query a jury should decide. It is within a layperson's grasp to conclude that some type of immediate medical care is necessary for a patient who has undergone a recent rectal surgery, is bleeding through the rectum, and is in extreme pain. *See Richards*, 548 N.W.2d at 89; *Ledford*, 105 F.3d at 360.

ii. Gil's inability to get an enema until 5/10/2000. Gil became severely constipated as a result of his rectal prolapse surgery. Despite complaining about his condition several times to medical staff, Gil was not allowed to get an enema until May 10 — more than ten days from his last bowel movement (and nine days from his surgery). *See supra* p. 16.

The district court ignored this claim, even though Gil raised it in response to Defendants' motion for summary judgment in the section on the FTCA claims. SA437. This claim warrants trial regardless of whether expert testimony is required: Dr. Kim testified that a patient in Gil's situation should receive an enema within four to five days after becoming constipated — and "definitely within a week." SA453 (33:11-22). That standard of care, supported by Dr. Kim's testimony, was not provided here.

CONCLUSION

The district court's order granting summary judgment to Defendants should be reversed and the case remanded for further action.

Respectfully submitted,

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