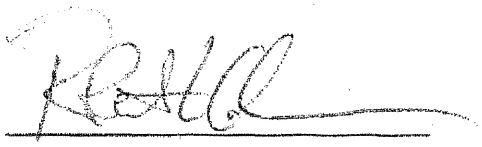
CONFIDENTIAL REBUTTAL REPORT OF ROBERT L. COHEN, M.D.

Parsons, et al. v Ryan, et al.

No. 2:12-cv-00601-NVW

JANUARY 31, 2014



Robert L. Cohen, M.D.

1. I have reviewed the Confidential Expert Report of Lawrence H. Mendel, D.O., and submit the following Rebuttal Report.

2. The overall message Dr. Mendel presents is that, while Arizona Department of Corrections had problems with health care delivery in the past, Corizon has "fundamentally changed" health care in the Arizona prisons, and "many of the issues raised in the original case have been addressed…." Mendel, 8. According to him, Corizon has transformed the health care delivery system so that the ADC is now operating "within the standard of care for correctional systems." *Id.* at 49.

3. As a preliminary matter, I am not familiar with the concept of a "standard of care for correctional systems." The duty of a physician is to deliver care to patients consistent with the community standard of care. It appears Dr. Mendel may believe a lesser standard of care applies when a patient is incarcerated. If that is his position, then I strongly disagree. If Dr. Mendel's point is that ADC is delivering health care consistent with the community standard, I also disagree. The delivery system that I observed, and the medical records that I have reviewed, provide no support for such an opinion. The death records for prisoners who died in mid-2012 (the latest date for which I was provided death records) vividly illustrate a deeply entrenched pattern of neglectful and harmful medical care resulting from widespread systemic deficiencies. The medical records I reviewed in July and thereafter, selected at random from lists of prisoners with medical care concerns, showed that prisoners continue to suffer because of unconscionable delays and neglect. This impression was amply supported by my observations while visiting prisons and talking to prisoners, and by my review of deposition transcripts and numerous other documents and records, including defendants' own system audits.

4. That the health care system has not fundamentally changed was made starkly apparent this month, when ADC and Corizon admitted that a Corizon nurse failed to follow standard injection protocols and may have exposed 24 prisoners at ASP-Lewis

to hepatitis B and C. The nurse administering the insulin pricked the patients' fingers to check their blood sugar and then used the same needle to draw insulin from a multi-use vial, thereby potentially contaminating the insulin provided to other patients. PLTF – PARSONS 031300. Remarkably, as I set forth in my initial report, there was a very similar exposure incident less than 18 months ago at this same prison, where more than 100 prisoners were also possibly exposed to hepatitis B and C due to faulty nurse practices under Wexford, the previous health care contractor. Unfortunately, this type of mistake is predictable, and even to be expected, in a system that is as understaffed and poorly managed as the Arizona Department of Corrections.

5. In my report, I documented numerous examples of failed care illustrating systemic deficiencies that expose ADC prisoners to harm and to risk of harm. Dr. Mendel charges that my report made no effort "to address whether the alleged deficiencies occurred during the period when treatment was provided by ADC, by Wexford, or by Corizon." Mendel, 48. I can only conclude that Dr. Mendel failed to read my report before responding to it. Had Dr. Mendel read my report, he would have observed that, with the exception of the death cases, virtually every patient I described in my report, and in appendix C to my report, suffered from poor care under Corizon, either exclusively, or because Corizon failed to remedy or continued to provide the poor care begun under ADC and Wexford.

6. [redacted] whose poor medical care I discuss at pages 5-8 of my report, is one of the many prisoners I discussed who has received poor care at ADC, including from Corizon. To recap, [redacted] was diagnosed with cancer in November, 2012, but defendants did not schedule any follow-up care for [redacted] for three and a half months, and his cancer was left untreated. Because of badly swollen lymph nodes, he requested to see a doctor by an HNR dated March 3, 2013. A physician's assistant requested that Corizon approve an urgent ENT consultation. Despite the presence of an untreated dangerous cancer, Corizon did not allow [redacted] to see an ENT surgeon

until May 14, 2013. The ENT surgeon requested a CT SCAN and an emergency consultation with an oncologist; these requests were directed to Corizon. The CT scan was not performed until July 2, 2013, 4 months after [redacted] complained by HNR of swollen lymph nodes. The CT SCAN, when finally done, showed a cancer of the upper throat. On Corizon's watch there were further delays in reviewing [redacted] CT report, and scheduling an appointment with an oncologist. As of July 17, 2013, on Corizon's watch, [redacted] had still not received any treatment for his cancer. Corizon ignored and failed to treat [redacted] cancer for more than 4 months. Had Dr. Mendel reviewed my discussion of [redacted] case, it is inconceivable he would have opined that I made no effort to address whether the atrocious care was provided by Corizon.

7. Dr. Mendel also asserts I made no effort to identify the causes of the "alleged deficiencies." I did - - Corizon is incapable of recognizing and responding to serious medical problems. Cohen, 8. Finally, Dr. Mendel questions whether I have opined that [redacted] "purported example[ ] of improper care" was the result of "an unfortunate outcome, a simple mistake, provider negligence, or a systemic problem." Mendel, 48. It is clear that [redacted] poor care is the result of an uncaring system of medical care, indifferent to a life-threatening cancer. I said so in my report: [redacted] care "is a horrifying example of a failed system that places every seriously ill man and woman it serves at extreme risk." Cohen, 8. That system is now being run by Corizon.

METHODOLOGY

8. In my initial report, I described the methodology I used to develop my opinions on the adequacy of the ADC health care delivery system. This process included two-day visits to two of ADC's largest facilities, as well as the review of numerous documents, including deposition testimony for ADC, Wexford and Corizon staff; documents produced to plaintiffs by ADC, including ADC's monthly contract monitoring reports, medical records and death reviews for patients who died, medical records for several named plaintiffs, and a randomly selected sample of medical records at the two

prisons that I visited. I selected the largest number of randomly selected medical records to review on site that was consistent with the time allowed by defendants for the site visit.

9. Dr. Mendel contends that, because the sample sizes at the two prisons I visited were limited, that no valid conclusions about gross systemic deficiencies could be drawn. Dr. Mendel mischaracterizes my report. As indicated above, the chart reviews were one factor that informed my opinions of the overall care. The charts I reviewed, randomly chosen from a sample of prisoners with emergency or chronic medical problems, amply demonstrated a level of dysfunction consistent with my observations while at ASPC-Eyman and ASPC-Lewis, my review of the ADC's own contract monitoring reports and other ADC data, and the ADC deposition testimony. Further, my opinions in this action draw upon my lengthy career in correctional health care, including as the Director of Rikers Island Health Services and as a medical expert in prison conditions cases over the past three decades, and on my review of medical literature.[1]

10. Based upon all of these factors, I state with a high degree of confidence that the ADC health care delivery system is fundamentally broken and among the worst prison health care systems I have seen.[2]

11. My opinion is based upon conditions, documents and records that have existed in the ADC for years and, according to the ADC monitoring reports and other ADC data, continued to exist through the end of September, 2013, which was the latest date for which I received information and records. Dr. Mendel seems to claim that, since September, Corizon has reversed course, and is now providing adequate care. Given the level of disarray I observed in records, documents, deposition transcripts and at the

[1] A complete list of the documents that I reviewed for purposes of preparing this rebuttal report is attached as Appendix A.

[2] I have learned that defendants recently provided to plaintiffs additional documents that Dr. Mendel relied upon for his expert opinion, in addition to the medical records for prisoners who have died since March 4, 2013. After reviewing them, I may include a discussion of those documents in my supplemental report.

facilities that I visited, and the ADC's recent press release describing the possible exposure of 24 prisoners to hepatitis B and C, I find Dr. Mendel's assertion that the ADC and Corizon have "reached a point where an inmate in ADC custody can expect timely access to appropriate care" (Mendel, 49) to be wholly implausible.

RESPONSE TO DR. MENDEL'S OPINIONS

Care for Named Plaintiffs

12. During my visits to Eyman and Lewis, I found numerous examples of significantly delayed care that subjected prisoners to harm and risk of harm. My report documents over three dozen recent cases in which patients should have been seen for acute care, chronic care, and/or specialty care, but did not receive timely care. Many suffered harm as a result and, sadly, I have learned that three of those patients have died since I reviewed their files. ([redacted].) Dr. Mendel does not dispute my analysis of these cases except with regards to NPs Swartz, Polson and Hefner.

13. I interviewed named plaintiff Mr. Swartz on July 15, 2013, and reviewed his medical record. Mr. Swartz submitted a health needs request (HNR) on January 13, 2013 requesting evaluation of an enlarging mass on his waist. My review of his medical record confirmed that Mr. Swartz waited five months to have this mass evaluated by a physician. Dr. Mendel's review of Mr. Swartz's medical records re-confirms that this long delay did occur, and further notes that the enlarging mass required surgical removal, which occurred on September 5, 2013.

14. Although Dr. Mendel states that there were no complaints regarding pain in 2013, review of the Mr. Swartz's medical record shows that he did complain of significant facial pain secondary to a 2010 traumatic event. The chart also shows that Mr. Swartz complained about this pain to Dr. Merchant on June 26, 2013. The record indicates that Dr. Merchant was aware of this pain, and ordered pain medication, tramadol, for this chronic pain. Dr. Merchant wrote that control of the chronic facial pain

might require prescription of a higher dose of pain medication. This medication had been prescribed previously, but the prescription had run out on April 23, 2013 and had not been renewed. ADC 122468

15. I interviewed named plaintiff Mr. Polson and reviewed his medical record. Mr. Polson reported to me on July 15, 2013 that he frequently was not provided with his ordered lithium carbonate, the medical treatment for his manic psychosis ordered by a psychiatrist. I reviewed his medical record and confirmed that during the three month period April through June, 2013, he had not received 42 out of 182 doses of his medication to prevent recurrence of mania. ADC 122345-122348. His lithium level was checked on June 13, 2013 and was found to be low, 0.3 meq/liter, well below the desired serum level of between .8meq/liter to 1.2 meq/liter. ADC 122344. The purpose of obtaining serum lithium levels is to assure that dosage is adequate, and not toxic. Despite this low level, no adjustment of his lithium dose was made, and no investigation of the cause of the low serum level was carried out. Inadequate doses of lithium carbonate, as reflected by serum level, are less likely to prevent recurrent episodes of mania. Mr. Polson was seen by a psychiatrist on May 13, 2013, who renewed the lithium prescription. However Mr. Polson received no lithium from May 7 through May 20, 2013.[3]

16. Mr. Polson also complained of chronic ear pain and delays in accessing ordered referrals to outside specialists. Dr. Mendel stated that "none of these claims have been substantiated in the expert reports." Mendel 13. In fact, medical staff from Eyman submitted a referral for Mr. Polson to see an otolaryngologist on June 28, 2011. The purpose of the consultation was to "Please evaluate (R) Hearing Loss, (B) Chronic Ear Pain (no current signs of infection), (and) Deviated Nasal Septum." The consult was finally approved, almost nine months later, on March 19, 2012. The approved consult

[3] In my Report, I incorrectly stated that Mr. Polson had not seen a psychiatrist since December, 2012. Cohen, 42.

never took place. A copy of the approved consult has a line through it with a handwritten notation marked "No Show." There is no indication on the consult form nor in the medical record of the reason why Mr. Polson was not brought to the appointment. ADC_M000195

17. Named plaintiff Hefner had surgery for removal of a cataract on June 13, 2013. Complications of cataract surgery are rare, but do occur. These complications include bacterial infection. Standard post-operative care includes examination by an ophthalmologist 1 day, seven days, and four weeks postoperatively.[4] Mr. Hefner developed disturbing symptoms several days later, including eye pain, flashing lights, and difficulty seeing and submitted an HNR on June 19, 2013. The ophthalmologist ordered steroid eye drops and antibiotic eye drops. The steroid eye drops were provided, but the prescribed antibiotic eye drops, ordered by the ophthalmologist, were not. Mr. Heffner did not receive the ordered antibiotic treatment given until July 15, 2013, four weeks later, the day I interviewed him. I did notify Dr. Winifred Williams, Corizon's regional medical director for Arizona, of my concern that Mr. Hefner was not receiving appropriate post-operative care**.**

Clinic Space

18. The clinic space at Eyman and Lewis prison complexes that I observed was insufficient for the number of prisoners served those prisons, and much of the space that was allocated appeared to be deserted and little used. At both complexes, I found that many of the clinical exam rooms were "locked, dark and empty." Cohen, 34, 37.

19. Dr. Mendel claims that he was shown the dark and empty rooms that I observed at Lewis, and that he was advised they were located in a unit that is not used because prisoners from that unit receive the majority of their care at "the hub." Mendel,

[4] Up-to-date, Cataracts in Adults, referenced January 26, 2014; http://www.uptodate.com/contents/cataract-in-adults?source=search_result&search=cataracts+in+adults&selectedTitle=1~150

47. He further claims that he "was told Dr. Cohen was informed of this information during his tour." *Id*. Dr. Mendel does not identify who provided him with this false information. While at Lewis, I visited the medical clinics at Rast and Barchey Units. I was advised by staff that all of the unit clinics were identical, and that they were used daily. While in Rast unit, I was told the clinic was not in use at the time of our visit because the pill nurse had to leave the clinic to provide named plaintiff Polson his psychiatric medications, based on our insistence that he receive them.

20. No one ever told me that the clinics were not in use because patients received care at the hub. On the contrary, both FHA Cameron Lewis and Dr. Williams advised me that the Lewis hub clinic was used only for specialty and emergency care, and all sick call and chronic care occurs in the unit clinics. Indeed, this arrangement is consistent with Dr. Mendel's description of the how the clinics are generally set up:

> In most cases, medical encounters occur on the prison unit where the inmate is assigned. ADC facilities generally consist of multiple units. Most of these units are surrounded by a separate secure perimeter and many have a specific program focus or security level. The provision of care at the prison unit decreases the need to move inmates and reduces the dependency of providers on the custody staff.

Mendel, 9.

Grievances

21. Dr. Mendel's report includes a section on his grievance review. Defendants did not produce the appeals that Dr. Mendel reviewed until January 30, 2014, making it impossible for me to review them in time to provide informed comment on his findings. However, I disagree with his implied assertion that grievances are a reliable indicator of the strength or weakness of a prison health care system. Grievances can, and should be, a component of quality assurance review. In a functioning health care system, grievances provide a mechanism for identifying individual health care needs which are not being adequately addressed, as well as identifying systemic problems. However, in July 2013,

prisoners in the prisons of Arizona consistently informed me that they were aware that the situation regarding health care services was extremely chaotic. Their descriptions of the magnitude of failures to provide them minimal access to nursing sick call, access to physicians, access to specialists, and access to medications was consistent with the findings in the monthly reports filed by Arizona Department of Correction Monitors in their monthly reports. See, *e.g.*, ADC 137185, 137201, 137268, 137465-66, 154050-51, 154148 (delays for nurse triage); ADC 88799, 088982, 137527-28, 154059-60; 154152-54 (delays for chronic care); ADC 088893, 089063, 137403 (delays for sick call); ADC 154056, 154151, 137343, 137270 (delays for specialty care). Prisoner observations were also consistent with the Wexford presentation to the AZ Department of Corrections on November 7, 2012. That Power Point presentation also described the systemic failure of the Arizona correctional health care program to provide basic services to prisoners.

22. In my opinion, the relatively low number of appeals, as reported by Dr. Mendel, more likely reflects the prisoners' understanding that the Arizona Department of Correction did not have the capacity to respond the their medical needs. Prisoners described to me that their HNRs would be returned with notations saying that their request for care has been noted, and that they were "scheduled to be scheduled" to be seen. They further reported that these appointments, when they did happen, were long delayed.

23. Dr. Mendel provides an analysis of grievances at only two institutions. The fact that the most serious grievances regarding necessary specialty consultations had been resolved at the time of his review reveals nothing about the significance of the grievance, the actual delay in access to services suffered by the prisoners, and the medical consequences of the delay.

Staffing

24. The staffing data Dr. Mendel relies on for October, 2013, which had not been available to me when I prepared my report, shows that the vacancy rates for Medical

Directors (must be filled by a physician) and staff physicians have risen sharply since Corizon's takeover. According to ADC's data, in March, 2013, Corizon had a 22% vacancy rate for Medical Directors, and a 20% vacancy rate for staff physicians. AGA_Review_00019436.[5] As of October, 2013, the vacancy rates for these two positions were considerably worse, 52% and 39% respectively. ADC 203041. At that point, the ADC had fewer than 11 full time physicians working at the ten state prisons, a ratio of 1 physician for every 3000+ state prisoners. Moreover, two of the full time physicians working in the prisons are Medical Directors in the larger prisons, and thus are unlikely to have significant clinical duties, which brings the ratio closer to 1 physician for every 3800 prisoners as a practical matter.

25. As of October, 2013 at the five larger prisons (all with prisoner populations greater than 4000), each had a combined vacancy rate of 50% or more for their physician positions, and Florence, with two staff physician and a medical director position, had just .8 of a physician, a 73% vacancy rate. This physician shortage at the larger prisons is particularly problematic because prisons of this size should have a Medical Director with few, if any, clinical duties.

26. According to Dr. Mendel, Corizon has directed "considerable efforts" to recruit providers, with "visible" results. Mendel, 20. In fact, Corizon's recruitment efforts for physician providers have obviously failed spectacularly.

27. Corizon's recruitment for Nurse Practitioner positions has had some success, as the vacancy rate has fallen from 51% in March, 2013, to 9% in October, 2013. That Corizon has filled some of the NP positions does not change my opinion that the ADC lacks sufficient staff to provide care to the 34,000 ADC state prisoners. While NPs are valuable members of a health care team, their scope of practice is more limited than the scope of a physician's practice, and thus, they cannot be substituted for physicians on

[5] Had Corizon not reduced the number of staff physician positions that month, the vacancy rate would have been at 45%. (AGA Review_00006402.)

a system-wide basis.

28. According to the latest data provided us by Dr. Mendel, there are approximately 45 mid and upper level medical providers working at ADOC facilities (including PRN and registry providers), with a population of 34,073.[6] California, with approximately three times the population of prisoners, had 386 medical providers for 123,334 prisoners in August 2014.[7] California has over twice the medical staffing ratio as Arizona. Dr. Mendel, appropriately, does not identify a national standard for medical staffing. The current staffing, in my opinion, is not adequate for the size and medical acuity of the prisoner population in Arizona.

29. In addition to recruitment of nurse practitioners, according to Dr. Mendel, Corizon addresses provider and nursing vacancies by contracting with temporary agencies. Mendel, 21. He claims that, during an eight month period, Corizon hired temporary physicians to provide over 4,000 hours of care, or approximately 500 hours per month. This works out to approximately 45 hours per month for each of the 11 state prisons, or one week's coverage. Clearly, this is grossly insufficient to address a system-wide 40-50% vacancy rate for physicians.

30. Moreover, reliance on temporary physicians is not an acceptable or sustainable strategy for covering ADC's long-term and intractable vacancies. Although there is no difference in the kind of medical care that prisoners need from that in the general populations, correctional health systems pose significant barriers to the delivery of minimally necessary care. Physicians who have not worked at the Arizona Department of Corrections need to be trained in the complexities of delivering care in a complex system which is not organized around patient need, but in which there are

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[6] http://www.azcorrections.gov/adc/reports/capacity/bed_2013/bed_capacity_oct13.pdf. PLTF-PARSONS 031601.

[7] http://www.cphcs.ca.gov/docs/special/Public-Dashboard-2013-08.pdf accessed 01/26/14

multiple, and constantly changing barriers to patient access, and to delivery of prescribed treatments. Physicians who have not worked in prisons are often understandably anxious, and overly dependent on correctional staff. They do not know what is allowed and what is forbidden, and thus may allow their clinical decisions to be guided by custody concerns rather than the community standard of care.

31. Additionally, the use of large numbers of temporary physician staff has a significant deleterious effect on the health care of prisoners at the ADC. Effective health care systems are built around providers who monitor their patients on a consistent basis and develop relationships with those who need regular care. This is especially true in the correctional setting for patients with chronic medical conditions. Chronic care of complex medical conditions cannot be effectively provided without continuity of provider, particularly in systems such as the ADC, where medical records are often poorly kept and chaotic. In my experience, having temporary medical staff rotate through clinical positions creates a much greater risk that patients will receive inadequate health care, particularly for their chronic health conditions. Continuity of physician care for patients with chronic illness is associated with decreased hospitalizations and emergency department visits, and improved receipt of preventive services.[8]

Access to Care/Wait times

32. As Dr. Mendel states, "[a]ccess to care is a quintessential element of correctional healthcare," and lengthy wait times for health care are not acceptable on a long term basis. Mendel, 9-10. Relying on data that was not previously provided to me, he claims that the "statewide provider wait time" has fallen significantly. *Id.*, 10

33. In my opinion, Dr. Mendel's discussion of wait times is based on incomplete data, his analysis of that data is flawed, and his conclusion that wait times

[8] Cabana MD, Jee SH., Does continuity of care improve patient outcomes?, *J Fam Pract.* 2004 December;53(12):974-9, PLTF-PARSONS-031892

have fallen statewide is unreliable. The analysis must be based upon several months of data, for each facility, with information provided regarding the numbers of each type of clinical encounter performed. Data must be presented for length of time from request to visit for HNR nurse visits, and for the length of time from request to provider encounter for nurse initiated physician visits. Dr. Mendel does not provide the data required to justify his conclusion.

CONCLUSION

34. Nothing in Dr. Mendel's report changes my opinion that the ADC health care delivery system is fundamentally broken, and that prisoners are at serious risk of harm because the system as a whole is not equipped to provide them with necessary care for their serious medical needs.

APPENDIX A

List of Documents Reviewed for Rebuttal Report

Documents cited in Appendix B of Cohen Report

Report of Lawrence H. Mendel

http://www.uptodate.com/contents/cataract-in-adults?source=search_result&search=cataract&selectedTitle=1~150

http://www.cphcs.ca.gov/docs/special/Public-Dashboard-2013-08.pdf

WEXFORD 000001	11/7/12 PowerPoint
ADC088796-088813	Compliance Report – Douglas – April 2013
ADC088892-088913	Compliance Report – Lewis – April 2013
ADC088979-088997	Compliance Report – Safford – April 2013
ADC089060-089083	Compliance Report – Winslow – April 2013
ADC122017	Corizon Inmate Wait Times Report – May 2013
ADC122338-122354	Polson, 187716, Medical Records
ADC122465-122490	Swartz, 102486, Medical Records
ADC137185-137200	Compliance Report – Douglas – July 2013
ADC137201-137228	Compliance Report – Eyman – July 2013
ADC137268-137288	Compliance Report – Lewis – July 2013
ADC137341-137359	Compliance Report – Safford – July 2013
ADC137402-137418	Compliance Report – Winslow – July 2013
ADC137465-137496	Compliance Report – Eyman – August 2013
ADC137525-137554	Compliance Report – Lewis – August 2013
ADC154049-154194	Compliance Report – Eyman – September 2013
ADC154147-154181	Compliance Report – Lewis – September 2013
ADC155093	Corizon Inmate Wait Times September 2013
ADC203041	Monthly Staffing Report October 2013
ADC203348	Corizon Inmate Wait Times Report November 2013
ADC_M000195-000206	Polson, 187716, ENT Records
AGA_REVIEW_0006402	AZ Staffing Comparison

AGA_REVIEW_00019436	October 2013 Corizon Staffing Report
PLTF-PARSONS-031592-0316032013	ADC Monthly Population Reports
PLTF-PARSONS-031300	ADC News Release, 1/9/14
PLTF-PARSONS-031892-031898	Cabana MD, Jee SH., Does continuity of care improve patient outcomes?. *J Fam Pract.* 2004 December;53(12):974-9