IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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LAMONT E. MOORE,

OPINION AND ORDER

Plaintiff,

10-cv-390-bbc

v.

DR. GLEN HEINZL,

Defendant.

- -

In this civil action for monetary and declaratory relief brought pursuant to 42 U.S.C. § 1983, plaintiff Lamont Moore contends that defendant Dr. Glen Heinzl failed to provide him adequate medical treatment in violation of the Eighth Amendment and state law. Now before the court is defendant's motion for summary judgment, in which defendant contends that no reasonable finder of fact could conclude from the evidence in the record that he was deliberately indifferent to plaintiff's serious medical needs or that he violated the applicable standard of care. Dkt. #28.

I conclude that defendant's motion must be granted. Although it is unfortunate that plaintiff's Lyme Disease was not diagnosed earlier, plaintiff has presented no evidence suggesting that defendant's treatment of plaintiff was unreasonable or a gross departure from

ordinary care under the circumstances. Therefore, defendant is entitled to summary judgment in his favor on plaintiff's constitutional claim. Fed. R. Civ. P. 56(a) (summary judgment must be granted "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law"). Also, defendant is entitled to summary judgment on plaintiff's state law claim because plaintiff has not submitted expert testimony establishing that defendant's actions fell below the standard of care under the circumstances.

From the parties' proposed findings of fact, I find the following facts to be material and undisputed.

UNDISPUTED FACTS

Plaintiff Lamont Moore is an inmate at Waupun Correctional Institution. During the events giving rise to this lawsuit, he was incarcerated at the New Lisbon Correctional Institution, where defendant Glen Heinzl has been employed as a physician since 2004.

On May 12, 2006, plaintiff submitted a health service request seeking an appointment with a doctor or nurse because he believed that he had pink eye. The following day, plaintiff was seen by a doctor who prescribed an antibiotic eye ointment. On May 15, 2006, plaintiff saw defendant for a follow-up appointment. After the appointment, defendant set up an appointment for plaintiff with an optometrist at a local clinic.

Plaintiff met with the optometrist on May 17, 2006. The optometrist diagnosed uveitis, which is an inflammation of the interior of the eye and is often a side effect of diseases in other parts of the body. The optometrist prescribed medication to treat the inflammation. The next day, plaintiff told a nurse in the health services unit that his eye felt better. Plaintiff met with the optometrist again on May 22, 2006. The optometrist began a tapering dose of plaintiff's medication and recommended that plaintiff be referred to the University of Wisconsin Hospital in Madison if his symptoms worsened or recurred.

On June 23, 2006, plaintiff saw an optometrist at the University Hospital, who prescribed Prednisolone Acetate eye drops and recommended various blood tests, including a test for HLA-B27. (The HLA-B27 test is used as one piece of evidence to support or rule out the diagnosis of certain autoimmune disorders that can cause uveitis.) On June 26, defendant signed the order authorizing the tests. The blood tests were drawn on June 29, and the results showed no evidence of diseases that are known to cause uveitis. (Plaintiff avers that defendant told him initially that the blood tests were positive for sarcoid or glaucoma). The blood tests did not test plaintiff for Lyme Disease.

On June 30, 2009, plaintiff was seen again at the University Hospital. It was decided that plaintiff would continue his present medications, although an ophthalmologist noted that because plaintiff had moderate to severe uveitis, he likely needed a periocular steroid.

On July 7, 2006, plaintiff had an outpatient follow-up visit at the University Hospital.

The doctors there recommended a chest x-ray and lab work to rule out certain conditions, including sarcoid. Upon plaintiff's return to prison, he denied any concerns to the nurse.

On July 23, 2006, plaintiff experienced eye pain and was seen by a nurse in the health services unit. He was instructed to take ibuprofen for the pain and to continue using sun shades. On July 28, August 14 and October 23, 2006, plaintiff was seen at the University Hospital for follow-up visits. Upon his return to the prison, he reported no medical concerns.

On November 3, 2006, plaintiff was seen at University of Wisconsin Ophthalmology and received eye injections and medication adjustments and was told to follow up in three to four weeks. Plaintiff went to the ophthalmology department again on December 1, 2006, and was given a diagnosis of bilateral anterior uveitis and cystoid macular edema in his right eye. On January 12, 2007, a physician at the University Hospital noted that the cystoid edema had improved.

On March 20, 2007, plaintiff submitted a health service request, complaining that his eyes were irritated and sensitive to light and that he had been feeling worse since he discontinued the prednisolone eye drops. In response to the recommendations of University physicians, plaintiff received another type of eye drop. The next day, plaintiff was seen by a nurse who flushed his eye with eye wash. He stated that it felt better. He was given the remainder of the eye wash to use on his own and was scheduled for a follow-up appointment

at the University Hospital. On April 23, 2007, plaintiff was seen at the University Hospital where his medications were adjusted.

In April, July and August 2007, plaintiff submitted health service requests complaining of pain, irritation, swelling, light sensitivity and blurred vision in his left eye. After several appointments at the prison, he was seen by an ophthalmologist at the University Hopsital on September 5, 2007. He was seen again on September 7 and 10 and was given a diagnosis of advanced glaucoma in his left eye. The attending physician recommended surgery. Plaintiff had glaucoma surgery on September 27, 2007, during which the doctor told plaintiff that his optic nerve was ruptured. After a series of follow-up appointments over the next four months, plaintiff was given a diagnosis of a left eye cataract.

Plaintiff had surgery on March 20, 2008 to remove his left eye cataract. He saw defendant in the health services unit on March 24 and was doing well. He also had several follow-up appointments at the University Hospital in March, April and May 2008.

On June 27, 2008, plaintiff complained that the vision in his right eye was distorted and getting worse. A nurse responded on June 29, telling plaintiff that he had an upcoming appointment with the University Hospital and would see defendant in July. Defendant saw plaintiff on July 25 and told nursing staff to move up plaintiff's appointment at the hospital.

At his hospital appointment on August 6, 2008, an ophthalmologist recommended that plaintiff have an Ocular Coherence Tomograph and possible "YAG capsulotomy."

These tests were administered on August 27, 2008, along with a visual fields test and eye pressure check. Plaintiff was seen at the University Hospital for follow-up appointments in September, October and December 2008, where it was recommended that he follow up in the prison clinic in two months.

On February 15, 2009, plaintiff submitted a health service request, complaining of blurry vision. Defendant arranged for the optometrist at the University Hospital to see him on February 18, 2009. Plaintiff was seen again at the University Hospital on March 4, 2009, where the optometrist recommended that plaintiff have cataract surgery for his right eye.

On April 28, 2009, plaintiff had cataract surgery on his right eye. After several follow-up appointments, plaintiff submitted a health service request in which he requested an appointment with defendant to discuss long-term steroid use and its side effects. Defendant told plaintiff that because the University Hospital ophthalmologists had prescribed the steroids, he should speak to them about his prescriptions at his next appointment.

On June 2, 2009, plaintiff submitted another health service request in which he complained that he was experiencing double vision in his right eye. Health services staff told plaintiff that they had contacted the University Eye Clinic about plaintiff's problem and that the clinic said plaintiff could wait until his next visit to be seen.

In June 2009, plaintiff was transferred to the Waupun Correctional Institution. On October 6, 2009, he was seen by Dr. Neal Barney, an Associate Professor of Ophthalmology

at the University of Wisconsin. At the time, plaintiff was taking prednisone, an oral steroid. In a letter to plaintiff's attending ophthalmologists, Dr. Barney indicated that since 2006, plaintiff's uveitis and glaucoma had been brought under control with the use of topical, pericular and oral steroids, but that plaintiff had developed uveitic glaucoma as well as steroid-responsive glaucoma necessitating his past surgeries. Dr. Barney referred plaintiff to the rheumatology department, hoping that the rheumatologists could suggest and manage a "steroid-sparing medication."

On October 13, 2009, plaintiff was seen by Dr. Sumnicht in the health services unit at the Waupun Correctional Institution. At the time, plaintiff was still on steroids and was experiencing muscle pain in his back. Dr. Sumnicht ordered a variety of lab tests, including a test for Lyme Disease. The lab tests were performed on October 29, 2009 and the IgM antibody was positive, indicating a new or active infection. (The parties dispute whether the IgG antibody that determines chronic or previous Lyme Disease was negative. Defendant avers that the antibody showing chronic or previous Lyme Disease was negative, suggesting that plaintiff likely had Lyme Disease for only a short period of time. Plaintiff contends that the antibody was positive and that even if it was negative, his long and continued use of oral steroids suppressed the Lyme antibodies. Both parties cite the same test results in support of their position without explaining the meaning of those results. Dkt. #32-5 at 133).

On November 25, 2009, Dr. Sumnicht gave plaintiff a medication to treat the Lyme Disease. During the course of the 30-day Lyme Disease treatment, plaintiff's uveitis cleared. By January 15, 2010, plaintiff's Lyme Disease was cured.

OPINION

A. Eighth Amendment Claim

The Eighth Amendment requires the government "'to provide medical care for those whom it is punishing by incarceration.'" Snipes v. DeTella, 95 F.3d 586, 590 (7th Cir. 1996) (quoting Estelle v. Gamble, 429 U.S. 97, 103 (1976)). To survive summary judgment on his Eighth Amendment medical care claim, plaintiff must submit evidence showing that he had a "serious medical need" and that prison officials were "deliberately indifferent" to this need. Estelle, 429 U.S. at 104; Gutierrez v. Peters, 111 F.3d 1364, 1369 (7th Cir. 1997).

Defendant does not deny the seriousness of plaintiff's glaucoma, cataracts, ruptured optic nerve and extreme light sensitivity, among other problems. However, defendant contends that there is no evidence in the record that he was deliberately indifferent to plaintiff's medical needs.

Deliberate indifference means that defendant knew of plaintiff's serious medical needs but failed to take reasonable measures to address them. Farmer, 511 U.S. at 847. Any

deliberate indifference analysis requires the court to consider the totality of the care provided. Dunigan v. Winnebago County, 165 F. 3d 587, 591 (7th Cir. 1999). When a doctor has provided a prisoner some treatment, the question is whether that treatment is constitutionally adequate, that is, whether the doctor acted with such blatant inappropriateness so to imply that his actions or omissions were not actually based on medical judgment. Duckworth v. Ahmad, 532 F.3d 675, 679 (7th Cir. 2008). Unless medical care evidences "intentional mistreatment likely to seriously aggravate the prisoner's condition," a prisoner's dissatisfaction with a doctor's prescribed course of treatment does not give rise to a constitutional claim. Snipes, 95 F.3d at 592.

Plaintiff has provided the court no factual basis for finding that defendant's medical care was blatantly inappropriate. Although plaintiff contends that defendant should have conducted tests to determine whether an infectious disease, such as Lyme Disease, was causing plaintiff's uveitis, he points to no evidence in the record that could establish that defendant's failure to conduct such tests was blatantly inappropriate or far below the general standard of care. Plaintiff's own say-so about what qualifies as appropriate medical treatment is not enough. The undisputed facts show that although defendant did not diagnose the source of plaintiff's eye problems, he continuously monitored and treated plaintiff's condition with examinations, testing, referrals to specialists and medication. In particular, defendant referred plaintiff to ophthalmologists and other specialists at the

University of Wisconsin Hospital and scheduled plaintiff for several follow-up appointments and surgeries there. Defendant personally evaluated plaintiff as well as relied on the diagnosis and medical judgments of University Hospital specialists. Although defendant did not diagnose plaintiff's Lyme Disease (which may or may not have been present at the time defendant was treating plaintiff), the facts in the record do not support a finding that defendant's failure to do so was medically inappropriate, let alone sufficiently reckless to amount to deliberate indifference. It would be next to impossible for plaintiff to argue successfully that defendant's actions were "far below the general standard of care when none of the specialists who saw plaintiff ever thought of Lyme Disease as a possible cause of plaintiff's problems. Accordingly, defendant's motion for summary judgment on plaintiff's Eighth Amendment claim will be granted.

B. Wisconsin Medical Negligence Claim

The next question is what to do with plaintiff's state law claim, in which he alleges that defendant's failure to diagnose his Lyme Disease constituted medical negligence under Wisconsin law. Under 28 U.S.C. § 1367(c)(3), a federal district court may decline to exercise supplemental jurisdiction over state law claims once federal claims have been dismissed. Indeed, the "general rule" is that state law claims should be dismissed when all federal law claims are dismissed before trial. Wright v. Associated Insurance Companies, Inc., 29 F.3d

1244, 1251 (7th Cir. 1994). It is only in certain "unusual" circumstances that those factors will warrant retaining jurisdiction. Id.; see also Hansen v. Board of Trustees, 551 F.3d 599, 608-09 (7th Cir. 2008) ("When all federal claims have been dismissed prior to trial, the principle of comity encourages federal courts to relinquish supplemental jurisdiction."). It may be proper to retain jurisdiction over state law claims under § 1367 when, for example, the statute of limitations has run on a state law claim, substantial judicial resources have been expended on the claims or resolution of the claims is clear. Wright, 29 F.3d at 1251-52; Hansen, 551 F.3d at 608-09.

Neither party addresses the question whether the court should retain jurisdiction over plaintiff's state law claim in the event plaintiff's federal claim is dismissed. However, I conclude that retaining jurisdiction is appropriate in this case because the resolution of plaintiff's state law claim is clear. In particular, I conclude that because plaintiff has presented no expert testimony regarding whether defendant breached the relevant standard of care, he cannot prove his medical negligence claim.

A claim for medical negligence, as with all claims for negligence, includes the following four elements: (1) a breach of (2) a duty owed (3) that results in (4) harm to the plaintiff. Paul v. Skemp, 2001 WI 42, ¶ 17, 242 Wis. 2d 507, 625 N.W.2d 860. Thus, to establish a prima facie medical negligence claim, plaintiff must show that defendant failed to use the required degree of skill exercised by an average physician, plaintiff was harmed and there is

a causal connection between defendant's failure and plaintiff's harm. Wis J-I Civil 1023. Unless the situation is one in which common knowledge affords a basis for finding negligence, medical malpractice cases require expert testimony to establish the standard of care. Carney-Hayes v. Northwest Wisconsin Home Care, Inc., 2005 WI 118, ¶ 37, 284 Wis. 2d 56, 699 N.W.2d 524. Plaintiff's situation is not one in which the common knowledge of laypersons affords a basis for finding negligence; in general, laypersons do not know whether a doctor should conduct a test for Lyme Disease when a patient is exhibiting symptoms similar to plaintiff's. (And, apparently, many doctors do not know this either, as demonstrated by the absence of any suggestion for such a test by the specialists who saw plaintiff at the University of Wisconsin Hospitals.)

Moreover, despite plaintiff's arguments to the contrary, the standard of care cannot be inferred from the record in this case. Plaintiff contends that because a specialist directed defendant to conduct blood tests on plaintiff, defendant should have conducted a test for Lyme Disease. In addition, plaintiff contends that the fact that Dr. Sumnicht tested plaintiff for Lyme Disease at the Waupun Correctional Institution shows that defendant should have tested plaintiff for Lyme Disease. However, there is no indication in the record that a specialist directed defendant to test for Lyme Disease or any other infectious disease or directed defendant to conduct follow-up blood work after the initial test results. Additionally, the fact that Dr. Sumnicht tested plaintiff for Lyme Disease in response to

plaintiff's complaints of muscle pain does not establish the standard of care for a physician trying to diagnose and treat eye inflammation and blurred vision.

In sum, this is a case in which an expert would be required to establish whether defendant's actions met the standard of care. Because plaintiff has submitted no expert testimony, defendant is entitled to summary judgment on plaintiff's state law claim. (Because I conclude that defendant is entitled to summary judgment, I need not resolve defendant's argument that plaintiff failed to comply strictly with Wisconsin's notice of claim statute, Wis. Stat. § 893.82(3) and (5m)).

ORDER

IT IS ORDERED that defendant Glen Heinzl's motion for summary judgment, dkt. #28, is GRANTED. The clerk of court is directed to enter judgment for defendant and close this case.

Entered this 18th day of July, 2011.

BY THE COURT:
/s/
BARBARA B. CRABB
District Judge