No. 21-___

IN THE

Supreme Court of the United States

ESTATE OF MADISON JODY JENSEN,
EX REL. JARED JENSEN,

Petitioner,

v.

KENNON TUBBS,

Respondent.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit**

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether private medical personnel working in correctional or mental-health facilities can assert qualified immunity.

RELATED PROCEEDINGS

Estate of Jensen ex rel. Jensen v. Clyde, No. 20-4024 (10th Cir.) (judgment entered Mar. 2, 2021).

Estate of Jensen ex rel. Jensen v. Tubbs, No. 20-4025 (10th Cir.) (judgment entered Mar. 2, 2021).*

Estate of Jensen ex rel. Jensen v. Duchesne Cnty., No. 17-cv-1031 (D. Utah) (order entered Jan. 21, 2020).

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* Consolidated on March 24, 2020, *see* Doc. 10727730 (10th Cir.).

PARTIES TO THE PROCEEDING AND RULE 29.6 DISCLOSURE STATEMENT

Petitioner is the Estate of Madison Jody Jensen, by and through her personal representative, Jared Jensen.

Respondent is Kennon Tubbs.

There are no publicly held corporations involved in this proceeding.

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INTRODUCTION

42 U.S.C. § 1983 affords individuals a right to recover from "[e]very person" who violates their constitutional rights while acting "under color" of state law. Although the text of that statute admits of no exceptions, this Court has held that it implicitly incorporates certain immunities that were available at common law. Over time, this Court has diverged from common-law standards with respect to claims of qualified immunity by government officials. With respect to private actors, however, it has held firm. Those actors, this Court has repeatedly made clear, are entitled to invoke qualified immunity only if (1) individuals performing similar functions were entitled to immunity at common law, and (2) public policy favors the extension of immunity. *See Wyatt v. Cole*, 504 U.S. 158, 163 (1992).

This Court has twice applied that standard since first adopting it in *Wyatt*. In *Richardson v. McKnight*, 521 U.S. 399 (1997), it found that neither history nor policy favored immunity for private prison guards. *Id.* at 412. And in *Filarsky v. Delia*, 566 U.S. 377 (2012), it found that both history and policy favored immunity for private lawyers working as city investigators. *Id.* at 380–84. In the years since *Filarsky*, however, the Courts of Appeals have struggled to reconcile those precedents. As a consequence, they have deeply divided with respect to the availability of qualified immunity for a third category of private actors: medical personnel working in correctional or mental-health facilities.

Respondent Kennon Tubbs is one such private actor. He was contractually responsible for the

provision of medical services at the Duchesne County Jail on November 27, 2016—the day 21-year-old Madison Jensen was arrested and detained on charges of drug possession. Upon arrival at the jail, she immediately began exhibiting symptoms of opioid withdrawal, including continuous vomiting and severe diarrhea. But her calls for help were all but ignored. Madison died of dehydration in her cell just four days after she arrived. She had lost seventeen pounds in that short period of time, and no medical treatment (apart from Gatorade) had ever been provided.

Madison's Estate sued Dr. Tubbs under 42 U.S.C. § 1983. Although the District Court found that a jury should decide whether Dr. Tubbs was responsible for a violation of Madison's constitutional rights, the Tenth Circuit reversed, holding that qualified immunity barred the Estate's claim. In so doing, the Tenth Circuit acknowledged a now four-to-two circuit split about whether qualified immunity is "available to a private medical professional providing services to a jail." Pet.App.14a n.2. The Sixth, Seventh, Ninth, and Eleventh Circuits, the court recognized, have held that qualified immunity is *not* available to such defendants. *See id.* The Fifth Circuit, by contrast, has held that at least some private medical personal *can* invoke that defense. *See id.* (citing *Perniciaro v. Lea*, 901 F.3d 241, 252 n.9 (5th Cir. 2018)). In endorsing immunity for private doctors like Dr. Tubbs, the Tenth Circuit threw its lot in with the Fifth. *Id.*

That division of authority really matters. More and more often, private medical personnel are responsible for providing healthcare to detainees across the country. And the availability of qualified immunity for those providers is frequently dispositive

of detainees' constitutional claims. Moreover, the methodological disagreements that underlie the medical-personnel circuit split have even broader implications. By answering the question presented, this Court would provide sorely needed guidance about the interaction between *Richardson* and *Filarsky*, and about the private-actor immunity standard more broadly.

In addition, the decision below is wrong. Every court to have considered the question has concluded that "there was no special immunity" at common law "for a doctor working for the state." *McCullum v. Tepe*, 693 F.3d 696, 703 (6th Cir. 2012). And the absence of a "tradition of immunity . . . firmly rooted in the common law" should be dispositive. *Wyatt*, 504 U.S. at 163–64. The Tenth Circuit's contrary approach—which ignores history and instead asks whether public employees could claim qualified immunity *today*—is irreconcilable with *Wyatt* and *Richardson*. And it misconstrues *Filarsky*. The Tenth Circuit's policy analysis is faulty, too. Doctors are subject to malpractice suits even for ordinary negligence, so there is no reason to expect that the possibility of liability under § 1983 will pose any serious problems.

This Court should grant certiorari and hold that private medical personnel like Dr. Tubbs are not entitled to invoke qualified immunity.

OPINIONS BELOW

The District Court's opinion denying summary judgment to Respondent Tubbs, Pet.App.22a–63a, is unpublished but is available at 2020 WL 291398 (D. Utah Jan. 21, 2020). The Tenth Circuit's decision

reversing that judgment, Pet.App.1a–21a, is published at 989 F.3d 848 (10th Cir. 2021).

JURISDICTION

The Tenth Circuit entered judgment on March 2, 2021. This petition was timely filed, consistent with the Supreme Court's March 19, 2020 Order, within 150 days of that judgment. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

42 U.S.C. § 1983 provides, in relevant part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .

STATEMENT

1. Section 1983 was first enacted in 1871. *See* Civil Rights Act of 1871, ch. 22, 17 Stat. 13, 13. It provides that "[e]very person who, under color of" state law, "subjects" another "to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured." 42 U.S.C. § 1983. "[O]n its face," the statute "admits of no immunities." *Wyatt*, 504 U.S. at 163 (quoting *Imbler v. Pachtman*, 424 U.S. 409 (1976)). Nevertheless, this Court has "accorded certain

government officials either absolute or qualified immunity from suit if the 'tradition of immunity was so firmly rooted in the common law'" at the time of § 1983's passage "'and was supported by such strong policy reasons that "Congress would have specifically so provided had it wished to abolish the doctrine."'" *Id.* at 163–64 (quoting *Owen v. City of Independence*, 445 U.S. 622, 637 (1980)).

In *Wyatt*, the Court considered whether qualified immunity can extend to "*private* defendants faced with § 1983 liability for invoking a state replevin, garnishment, or attachment statute." *Id.* at 168–69 (emphasis added). Although the Court did "not foreclose the possibility that private defendants faced with § 1983 liability" could invoke qualified immunity in some contexts, it held that the private defendants at issue could not. *Id.* Similar actors, the Court reasoned, were not entitled to immunity at common law. *See id.* at 164–65. Moreover, the policy "rationales mandating qualified immunity for public officials are not applicable to private parties." *Id.* at 167.

This Court applied the same history- and policy-based standard in *Richardson v. McKnight*, 521 U.S. 399 (1997). The defendants in that case were "prison guards who [were] employees of a private prison management firm." *Id.* at 401. After examining case law from the eighteenth to early twentieth centuries, the Court found "no conclusive evidence of a historical tradition of immunity for private parties carrying out" "prison management activities." *Id.* at 407. The Court further reasoned that extending immunity would not serve public policy because the "competitive market pressures" that "a private company" faces suffice to

guard against "unwarranted timidity" and the deterrence of "talented candidates." *Id.* at 409–11 (quoting *Wyatt*, 504 U.S. at 167).

The Court again considered the applicability of qualified immunity to private individuals in *Filarsky v. Delia*, 566 U.S. 377 (2012). This time, the defendant was a private lawyer who had worked on behalf of a city in an investigative capacity. *Id.* at 380–81. It was undisputed that immunity generally existed at common law "for the sort of investigative activities at issue," such that a full-time government employee engaged in those activities could invoke immunity. *Id.* at 384. The only question was whether the defendant's employment "on something other than a permanent or full-time basis" rendered immunity unavailable. *Id.* at 380. Looking first to history, the Court determined that "the common law" in 1871 "did not draw a distinction between public servants and private individuals engaged in public service in according protection to those carrying out government responsibilities." *Id.* at 387. It then found that no policy considerations "counsel[ed] against carrying forward the common-law rule." *Id.* at 389. Accordingly, the Court held that the defendant could assert qualified immunity. *Id.* at 394.

2. This case is about the interaction of these precedents. It arises from the tragic and eminently preventable death of Madison Jensen, who died at the age of 21 while in the custody of the Duchesne County Jail. At the time of Madison's death, the jail contracted with Respondent Kennon Tubbs, a private physician, to serve as the jail's Medical Director and provide medical services to its inmates. Pet.App.5a. Pursuant to that contract, Dr. Tubbs provided 24/7 on-

demand services to the jail; he also subcontracted with a physician's assistant who visited the jail weekly. *Id.* In addition, Dr. Tubbs was responsible for "provid[ing] training, instruction, support, and a supervisory role [for] nursing staff on how to appropriately handle triage, sick call, medical protocols, and health care complaints/grievances." *Id.*

The jail itself had a single medical employee, a licensed practical nurse named Jana Clyde. *Id.* at 4a. A licensed practical nurse certification does not require an associate's or bachelor's degree in nursing. *Id.* And by law, a licensed practical nurse is forbidden from conducting health assessments or diagnosing or treating any medical condition. *Id.* at 24a. Instead, Ms. Clyde's role was merely to administer medications, check vital signs, and report to her superiors. *Id.* at 4a. Although Dr. Tubbs was responsible for training and supervising Ms. Clyde, she stated that she had never been "given a Jail policies and procedures manual" and had "not receive[d] any training . . . on the Jail's medical policies and procedures." *Id.* at 32a.

On November 27, 2016, Madison's father noticed that she was acting strangely, and she admitted that she had recently taken heroin and other drugs. *Id.* at 23a. He called the local sheriff's office for assistance. *Id.* When officers arrived at the Jensen home, they placed Madison under arrest and then booked her into the Duchesne County Jail. *Id.* at 4a. Madison told the arresting officer that "she was 'coming off' heroin." *Id.* And during intake, Madison informed a corrections officer that she had "recently" used heroin. *Id.* Unsurprisingly, moreover, her "urinalysis test was positive for opiates." *Id.* at 26a.

Madison spent the next four days going through opioid withdrawal. *Id.* at 5a–8a. She vomited continuously, and she repeatedly suffered from severe diarrhea. *Id.* Madison and her cellmate used a call button over and over to notify jail staff that Madison was "violently" ill—to the point that a deputy told them "to stop pushing the call button." *Id.* at 27a. Madison was unable to hold down food or even water, *id.* at 6a, and she lost seventeen pounds in the short period of time she was detained, *id.* at 8a. Watching Madison deteriorate, one guard remarked to his wife that "Madison looked like she was going to die because 'she was just like a skeleton.'" *Id.* at 29a.

Despite the severity of Madison's condition and the indications that she was experiencing opioid withdrawal, Ms. Clyde purportedly believed that Madison only had a stomach flu. *Id.* at 30a. She gave Madison Gatorade, *id.* at 6a, but she did not contact Dr. Tubbs, monitor Madison's vital signs, or attempt to provide any further medical treatment. *Id.* According to Ms. Clyde, "she was not required to take an inmate's vital signs each day even if she knew the inmate was exhibiting obvious symptoms of severe dehydration." *Id.* at 33a. And "there is conflicting testimony about when she was expected to contact [Dr. Tubbs] regarding an inmate who was vomiting, experiencing diarrhea, or exhibiting signs of dehydration." *Id.*

At 1:00 P.M. on December 1, 2019, four days after Madison had entered the jail, she vomited brown liquid and then had a seizure, which caused her to roll out of bed and onto the floor. *Id.* at 31a. She was discovered dead in her cell approximately thirty minutes later. *Id.* No doctor or physician's assistant

had ever been called, and no medical treatment (apart from Gatorade) had ever been provided. *Id.* at 5a–8a. The cause of Madison's death was found to be dehydration due to opioid withdrawal. *Id.* at 7a. An autopsy revealed that she had gallstones—evidence of severe dehydration—and that, at 5'11", she weighed just 112 pounds at the time of her death. *Id.* at 35a; D. Ct. Dkt. 91, 2d Amended Compl. ("Am. Compl.") ¶ 150.

3. Madison's Estate, the Petitioner here, filed suit against Dr. Tubbs, among others, in the District Court for the District of Utah. Am. Compl. ¶ 6; *see also* 28 U.S.C. § 1331 (conferring federal jurisdiction). The Estate alleged that Dr. Tubbs is liable under § 1983 for failing to implement policies, procedures, and training regarding how to treat or respond to inmates showing signs of opioid withdrawal or severe dehydration. *See* Am. Compl. ¶¶ 290–329. Dr. Tubbs moved for summary judgment, arguing that he was entitled to qualified immunity from the Estate's suit as a matter of law. D. Ct. Dkt. 141.

The District Court denied his motion. "Dr. Tubbs acknowledge[d] that he was responsible for Nurse Clyde's training." Pet.App.58a. But he presented "no evidence" that any such training had been provided. *Id.* And there were "no written procedures, policies, or training materials." *Id.* at 57a. Moreover, in Madison's case, Ms. Clyde had "failed to document Madison's condition" and had "failed to engage in basic follow up," "call[ing] into question what kind of training [she] had received." *Id.* at 58a. Indeed, there was "no evidence that [Ms.] Clyde was trained in how to find out or document relevant information from patients." *Id.* And "[i]f there were no protocols or

training for obtaining relevant information from patients," the court reasoned, "a constitutional violation was certain to occur at some point." *Id.* at 59a. "[W]hether or not qualified immunity is available to a contract doctor," the court thus concluded, "questions of fact regarding Dr. Tubbs' potential supervisory liability preclude[ ] the application of [that] defense prior to trial." *Id.* at 60a.

4. The Tenth Circuit took an interlocutory appeal and reversed. The court began with the question whether Dr. Tubbs, as "a private physician," was "entitled to claim qualified immunity." *Id.* at 10a. The court read *Filarsky* to establish that, under common law principles, "immunity should not vary depending on whether the individual works for the government on a part-time or full-time basis." *Id.* at 11a. Dr. Tubbs, the court reasoned, "would have certainly been able to raise a qualified-immunity defense" "had [he] been working as a doctor for the county on a full-time basis." *Id.* at 11a–12a. "Thus," the court concluded, "common law principles support Dr. Tubbs' ability to raise a qualified-immunity defense." *Id.* at 12a.

The Tenth Circuit then turned to public policy considerations, which it found also favored qualified immunity. In particular, the court opined that the defense would both prevent "'unwarranted timidity'" and minimize the "distract[ions]" of litigation. *Id.* (quoting *Richardson*, 521 U.S. at 408–11). It also expressed concern that "talented candidates could be deterred" absent qualified immunity because "a physician like Dr. Tubbs does not 'depend on the government for [his] livelihood.'" *Id.* at 13a (alteration in original) (quoting *Filarsky*, 566 U.S. at 390). The "'market pressures at play within a purely private

firm,'" the court asserted, "'simply do not reach'" "private doctors providing services at a jail." *Id.* (quoting *Perniciaro*, 901 F.3d at 253).

In holding that "Dr. Tubbs may claim qualified immunity," the Tenth Circuit acknowledged an entrenched circuit split about whether "qualified immunity is . . . available to a private medical professional providing services to a jail." *Id.* at 14a–15a & n.2. The Sixth, Seventh, Ninth, and Eleventh Circuits, it recognized, have said "no." *Id.*; *see McCullum*, 693 F.3d at 704; *Est. of Clark v. Walker*, 865 F.3d 544, 551 (7th Cir. 2017); *Jensen v. Lane Cnty.*, 222 F.3d 570, 577 (9th Cir. 2000) ("*Lane County*"); *Hinson v. Edmond*, 192 F.3d 1342, 1347 (11th Cir. 1999), *amended*, 205 F.3d 1264 (11th Cir. 2000). The Fifth Circuit, on the other hand, has said "yes." Pet.App.14a n.2; *see also Perniciaro*, 901 F.3d at 255. The Tenth Circuit sided with the Fifth Circuit's minority view. In rejecting the majority position, the court suggested that decisions denying qualified immunity to private prison doctors "may not align precisely with *Filarsky*'s mode of analysis." Pet.App.14a n.2 (citing *Perniciaro*, 901 F.3d at 252 n.9).

Having found qualified immunity available, the Tenth Circuit then turned to its application. The Estate, it concluded, had failed to "establish the requisite degree of personal involvement, causation, and state of mind" and to present "enough" case law "to make it clear to Dr. Tubbs that he was violating Ms. Jensen's rights in this context." *Id.* at 16a–18a.

Accordingly, the court held that "Dr. Tubbs is entitled to qualified immunity" from the Estate's suit. *Id.*[1]

REASONS FOR GRANTING THE WRIT

The Courts of Appeals have split four-to-two on the question whether private medical personnel working in correctional or mental-health facilities can assert qualified immunity. That split is both entrenched and acknowledged. It directly affects thousands of prisoners and prison workers throughout the country. And the methodological disagreements from which it stems have implications for the availability of qualified immunity in other contexts, too. Moreover, the decision below is wrong: As every circuit to have considered the question has concluded, doctors were *not* entitled to immunity at common law, even when performing government services. And even if policy were enough to overcome a dearth of historical support, the policy rationales that justify immunity for government officials do not extend to private physicians. Certiorari should be granted.

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[1] Separately, the Tenth Circuit "affirm[ed] the district court's decision that Ms. Clyde [was] not entitled to qualified immunity." Pet.App.21a. "Despite th[e] obvious risk to Ms. Jensen," it reasoned, "Ms. Clyde failed to take any reasonable measures." *Id.* at 19a. And it was "clearly established" that "ignoring" a detainee's "obvious and serious medical needs . . . necessarily violates the detainee's constitutional rights." *Id.* at 20a. That ruling is not at issue here.

I. THE COURTS OF APPEALS ARE DIVIDED.

A. Four Circuits Have Held That Private Medical Personnel Can Never Assert Qualified Immunity.

The Sixth, Seventh, Ninth, and Eleventh Circuits have held that private medical personnel in correctional and mental-health facilities categorically cannot raise a qualified-immunity defense. Relying primarily on *Richardson*, these circuits have reached that result by asking whether a person performing the defendant's functions would have had immunity *in 1871*.

1. In *Hinson v. Edmond*, the Eleventh Circuit considered whether "a privately employed prison physician[ ]" working at a county jail could invoke qualified immunity. 192 F.3d at 1343. In so doing, the court first considered whether a "'firmly rooted' tradition of immunity applicable to privately employed prison physicians exists." *Id.* at 1345. It found no such tradition "for acts amounting to recklessness or intentional wrongdoing." *Id.* It further found that "the public policy reasons for qualified immunity [did] not justify the extension of qualified immunity" to private prison doctors like the defendant. *Id.* at 1346. The court therefore held that private prison physicians are "ineligible to advance the defense of qualified immunity." *Id.* at 1343.

2. The Ninth Circuit reached the same result in *Jensen v. Lane County*, which involved "a private medical practitioner" "asked by the government to make a decision to commit persons suspected of mental illness." 222 F.3d at 572, 576. Like the Eleventh Circuit, the Ninth Circuit first considered

"the historical availability of immunity" for such practitioners. *Id.* at 576. The court found no "definitive common law history of immunity." *Id.* at 577. It also found that public policy militated against the extension of immunity. *Id.* at 578. Accordingly, the court held that private practitioners cannot invoke qualified immunity. *See id.* at 572.

3. The Sixth Circuit adopted the same rule, for the same reasons, in *McCullum*. 693 F.3d at 696. First, the court determined that "there was no common-law tradition of immunity for a private doctor working for a public institution at the time that Congress passed § 1983." *Id.* at 704. Although the court noted that it was "questionable whether" courts could rely on policy to "extend qualified immunity where there was no history of immunity at common law," it nevertheless considered policy "out of an abundance of caution." *Id.* at 700 n.7. And it concluded that the "same factors" the Court considered in *Richardson* rendered immunity "inappropriate here." *Id.* at 704. The court therefore held that "private doctor[s] working for the government" cannot invoke qualified immunity. *Id.* And the Sixth Circuit recently reaffirmed that rule in *Berkshire v. Beauvais*. 928 F.3d 520, 531 (6th Cir. 2019) (relying on *McCullum* for the proposition that "a private doctor working for the government is not entitled to qualified immunity").

4. The Seventh Circuit endorsed "the Sixth Circuit's reasoning" in *Estate of Clark v. Walker*, 865 F.3d 544, 551 (7th Cir. 2017). The proper "historical inquiry," the court explained, is "whether the person asserting qualified immunity would have been immune from liability under the common law in 1871." *Id.* at 550. In "'the absence of any indicia that a paid

physician . . . would have been immune from suit at common law,'" the court held that "private medical personnel in prisons are not afforded qualified immunity." *Id.* at 550–51 (quoting *McCullum*, 693 F.3d at 704). That result, the court further explained, was consistent with its prior rulings in other "other post-*Filarsky* cases." *Id.* at 551 (citing, *e.g.*, *Petties v. Carter*, 836 F.3d 722, 734 (7th Cir. 2016), *as amended* (Aug. 25, 2016) ("[Q]ualified immunity does not apply to private medical personnel in prisons.")).

B. Two Circuits Have Held That Some Private Medical Personnel *Can* Assert Qualified Immunity.

By contrast, the Fifth and Tenth Circuits have held that qualified immunity extends to at least some private medical personnel working in correctional and mental-health facilities. Relying primarily on *Filarsky*, these circuits have reached that result by asking whether a full-time government employee performing the defendant's functions would have immunity *today*.

1. In *Perniciaro v. Lea*, the Fifth Circuit granted qualified immunity to psychiatrists employed by a private university who provided services at a state-run mental-health facility. 901 F.3d at 246. The availability of qualified immunity, the court emphasized, should not turn "on whether an individual working for the government does so as a full-time employee, or on some other basis." *Id.* at 252 (quoting *Filarsky*, 566 U.S. at 389). And because the defendants' "public counterparts would be entitled to assert qualified immunity," the court held that "general principles of immunity at common law

support [the defendants'] right . . . to raise th[at] defense" too. *Id.* The court further found that policy considerations supported extending immunity to private physicians, citing concerns about whether "'ordinary marketplace pressures'" would otherwise "suffice to incentivize vigorous performance and prevent unwarranted timidity." *Id.* at 253 (quoting *Richardson*, 521 U.S. at 409–10).

In reaching this conclusion, the Fifth Circuit expressly disagreed with the "contrary conclusions in [*Lane County*] and *Hinson*," as well as in "*McCullum*." *Id.* at 252 n.9. In particular, the court criticized its sister circuits for "fram[ing] the relevant question as whether there was a firmly-rooted tradition of immunity for private doctors performing some government-related function." *Id.* Instead—and while noting particular "respect for [the Sixth] [C]ircuit's deep historical analysis of whether doctors had any special immunity at common law"—the Fifth Circuit read *Filarsky* to require consideration only of whether the common law generally supported distinguishing between public and private individuals. *Id.*[2]

2. In the decision below, the Tenth Circuit followed the Fifth. *See supra* at 10–12. The key

[2] The Fifth Circuit recently reaffirmed *Perniciaro*'s holding that private physicians are generally entitled to assert qualified immunity. *Sanchez v. Oliver*, 995 F.3d 461, 467 (5th Cir. 2021) (discussing *Perniciaro*, 901 F.3d at 254). The court held, however, that employees of "a major corporation 'in the business of administering correctional health care services'" cannot invoke qualified immunity, because neither history nor policy supports the extension of immunity to that particular context. *Id.* at 466–72.

common-law "principle[ ]," the court explained, "is that immunity should not vary depending on whether the individual works for the government on a part-time or full-time basis." Pet.App.11a. Accordingly, the court held that "a private doctor" who had contracted with a jail "to provide some medical services" could assert qualified immunity, because a doctor providing the same services for the jail "on a full-time basis . . . would have certainly been able to raise a qualified-immunity defense." *Id.* at 5a, 11a–12a; *see also Estate of Lockett ex rel. Lockett v. Fallin*, 841 F.3d 1098, 1109 (10th Cir. 2016) (holding that "a private doctor" hired to carry out an execution could assert qualified immunity because "a permanent government employee" who performed the same job would be able to raise the defense).

In so holding, the Tenth Circuit acknowledged that four "other circuits" had "conclud[ed] that qualified immunity is *not* available to a private medical professional providing services to a jail." Pet.App.14a n.2 (emphasis added)). The court did not question those circuits' conclusion that "there was no common-law tradition of immunity for private doctors" in 1871. *Id.* at 15a. Like the Fifth Circuit, the court simply "read *Filarsky* to require a different focus." *Id.* (quoting *Perniciaro*, 901 F.3d at 252 n.9).[3]

[3] The Tenth Circuit reaffirmed that a "doctor who [i]s engaged part time by a county jail" can "assert the defense" of qualified immunity in another decision issued the very same day as this one. *Tanner v. McMurray*, 989 F.3d 860, 864 (10th Cir. 2021) (citing *Est. of Jensen*, 989 F.3d 848). But like the Fifth Circuit in *Sanchez*, the court held in that case that "full-time employees of a for-profit, multi-state corporation organized to

C. The Split Is Well Developed And Entrenched.

The Courts of Appeals have thus sharply defined the crux of their disagreement. All agree that physicians did not enjoy any special immunity from suit in 1871. *See, e.g.*, *Sanchez v. Oliver*, 995 F.3d 461, 468 (5th Cir. 2021) ("[A]ll of our sister circuits to have considered the issue have found no compelling history of immunity for private medical providers in a correctional setting."). And none disputes that state physicians can assert qualified immunity today. *See, e.g.*, *Perniciaro*, 901 F.3d at 252 ("[I]t is clear that their public counterparts would be entitled to assert qualified immunity[.]"). They diverge, however, as to which of these two undisputed propositions controls the availability of qualified immunity for private physicians working in state facilities.

That divergence stems from tensions in this Court's own case law. On the one hand, *Richardson* framed the historical inquiry as whether an actor performing the same function in 1871 would be immune from suit. 521 U.S. at 404–07. The circuits principally relying on *Richardson* have thus held that qualified immunity is categorically unavailable to private medical personnel like Dr. Tubbs. *See, e.g.*, *Clark*, 865 F.3d at 550 (following *Richardson* because "*Filarsky* did not overrule *Richardson*"). On the other hand, *Filarsky* can be read to focus on whether common-law principles support treating defendants that work for the government on a part-time basis differently from those who work for the government

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provide contract medical care in detention facilities" cannot invoke qualified immunity. *Id.* at 861.

full-time. *Filarsky*, 566 U.S. at 384–89. The circuits principally relying on *Filarsky* have thus held that qualified immunity is available to private medical personnel like Dr. Tubbs. *See, e.g.*, *Perniciaro*, 901 F.3d at 252 n.9 (criticizing circuits denying qualified immunity for "follow[ing] *Richardson*'s lead" when "*Filarsky* . . . require[s] a different focus").

Only this Court can resolve the perceived tension between *Richardson* and *Filarsky* and restore uniformity to the law.

II. THE QUESTION PRESENTED MERITS THE COURT'S ATTENTION.

The question presented is important. An increasing majority of the nation's correctional facilities employ private medical professionals to care for prisoners. And prisoner deaths—including from alcohol- or drug-related causes—are on the rise. The availability of qualified immunity for private physicians often proves dispositive of prisoners' constitutional claims. Moreover, broader methodological questions about the interaction between *Richardson* and *Filarsky* have implications for the availability of immunity in myriad other contexts. This case is an ideal vehicle not only for resolving the division of authority about qualified immunity for private prison doctors, but also for clarifying the standard for private-actor immunity claims more broadly.

1. In fiscal year 2015, Pew reported that twenty states contracted out "most health care service delivery" in their prisons, and another eight states relied on "a roughly even mix of state employees and contracted vendors." Pew Charitable Trusts, *Prison*

Health Care: Costs and Quality 10 (2017), https://tinyurl.com/3zzcs2z9; *see also* Lauren Galik & Leonard Gilroy, *Public-Private Partnerships in Correctional Health Care*, REASON FOUND., 2–3 (2014), https://tinyurl.com/f243azev (noting that thirty-six states contracted out at least some of their prison healthcare services to private vendors in 2014). And a 2020 Reuters survey of 500 jails across the country revealed that reliance on private medical professionals has only increased over time, with 62% of those jails reporting at least some use of private medical providers. *See* Jason Szep et al., *Dying Inside: The Hidden Crisis in America's Jails Part Two*, REUTERS (Oct. 26, 2020), https://tinyurl.com/hz8wpsev.

All signs suggest that trend will continue. The nation's prison population is aging. *See* Pew Charitable Trusts, *supra*, at 25–26 ("From 1999 to 2015, the number of people age 55 or older in state and federal prisons . . . increased 264 percent. . . . [T]he share of individuals age 55 and over [has] increased in nearly every state prison system."). And older prisoners require substantially more medical care than their younger counterparts. *Id.* at 27. States will have to spend more and more on healthcare as their prison populations age, increasing incentives to cut costs through privatization. *Cf.* W. J. Michael Cody & Andy D. Bennett, *The Privatization of Correctional Institutions: The Tennessee Experience*, 40 VAND. L. REV. 829, 847 (1987) (cited in *Richardson*, 521 U.S. at 402) (explaining that "reducing costs is probably the most important reason for privatizing correctional facilities"). That means, in all likelihood, that States will continue to rely on private medical personnel in their correctional and mental-health facilities.

Detainee deaths are also on the rise. *See* E. Ann Carson, *Mortality in Local Jails, 2000–2018 – Statistical Tables*, U.S. DOJ, BUREAU OF JUST. STAT. 1–2 (April 2021), https://bjs.ojp.gov/content/pub/pdf/mlj0018st.pdf. Indeed, prisoner deaths due to drug or alcohol intoxication have more than quadrupled in the past twenty years. *See id.* And prisoners who died of drug or alcohol intoxication in a local jail had served a median of just *one day* before death. *Id.* at 3. As these statistics reveal, deaths like Madison's are all too common—and it is often private doctors, not state employees, who are potentially responsible.

2. The availability of qualified immunity for private medical personnel really matters. A defendant who can assert qualified immunity can be held liable only if "existing precedent [has] place[d] the lawfulness of the particular [action] beyond debate." *City of Escondido v. Emmons*, 139 S. Ct. 500, 504 (2019) (third alteration in original). As a result, "qualified immunity protects 'all but the plainly incompetent or those who knowingly violate the law.'" *Mullenix v. Luna*, 577 U.S. 7, 12 (2015). And the availability of qualified immunity is often dispositive of whether a prisoner who has suffered a constitutional injury at the hands of a private medical professional has any meaningful remedy. *See, e.g.*, *Gaines v. Wardynski*, 871 F.3d 1203, 1210 (11th Cir. 2017) (acknowledging that an immunity defense "almost always protects the defendant"). The circuit split, accordingly, means that the availability of redress for violations of a prisoner's constitutional rights can turn on where in the country she happens to be detained.

The split also makes it difficult for medical professionals working in correctional facilities and the governments that engage them. "A contractor's price must depend upon its costs," and lawsuits—"even . . . lawsuits that have been insured against"—invariably "increase costs." *Richardson*, 521 U.S. at 419 & n.3 (Scalia, J., dissenting). So long as it remains uncertain whether private medical personnel can assert qualified immunity, medical contractors will not be able to accurately assess the costs of working in state facilities. And that uncertainty will hinder contractors and governments from reaching mutually agreeable terms for the provision of healthcare to detainees.

For just these sorts of reasons, this Court has twice granted certiorari in the wake of *Wyatt* to resolve divisions of authority regarding the scope of qualified immunity for private persons. *See id.* at 401; *Filarsky*, 566 U.S. at 380. But in the nearly ten years since *Filarsky*, the Courts of Appeals have struggled to reconcile those precedents. And the question whether qualified immunity is available to private doctors is arguably even *more* important than the ones this Court has taken up previously. More prisoners are held in jails that rely on private medical providers than in private prisons (the issue in *Richardson*). *Compare Dying Inside*, *supra* (noting that 62% of the surveyed jails relied on privatized medical care in 2018), *with* Pew Charitable Trusts, *supra*, at 14 (noting that "[n]early nine in 10 inmates . . . were housed in state-run prisons" in 2015). Moreover, prison medical personnel are much more likely to be private actors than are government lawyers (the issue in *Filarsky*). *See* Margaret H. Lemos, *Privatizing*

Public Litigation, 104 GEO. L.J. 515, 517 (2016) (noting that "our system [has] 'publicized' most litigation in the name of the government, shifting control from private actors to salaried public servants").

3. The question presented also has implications for the availability of qualified immunity for private individuals in other contexts. In attempting to apply *Richardson* and *Filarsky*, lower courts agree that common-law tradition and public policy are both relevant to determining whether a private person can invoke qualified immunity. But they do not agree about how that common-law inquiry should be conducted, or about how public policy figures in. These methodological questions are not limited to cases involving medical personnel; they arise every time courts are asked to decide whether private actors can raise an immunity defense.

With respect to common-law methodology, decisions denying qualified immunity to private medical providers ask, in reliance on *Richardson*, whether a person performing the defendant's particular functions would have had immunity *in 1871*. *See Clark*, 865 F.3d at 550–51; *McCullum*, 693 F.3d at 700; *Lane County*, 222 F.3d at 577; *Hinson*, 192 F.3d at 1345–46. By contrast, decisions granting qualified immunity to private medical providers ask, in reliance on *Filarsky*, whether a full-time government employee performing the defendant's functions would have immunity *today*. *See* Pet.App. 15a; *Perniciaro*, 901 F.3d at 252 & n.9.

The very same rift is apparent in cases addressing the availability of immunity for private actors in other

contexts. In *Bracken v. Okura*, for example, the Ninth Circuit held that an off-duty officer acting as a private security guard could not invoke qualified immunity because there was "no 'firmly rooted' tradition of immunity" for such actors. 869 F.3d 771, 777 (9th Cir. 2017). Likewise, in *Gregg v. Ham*, the Fourth Circuit held that a bail-bond provider could not invoke qualified immunity because "there is no evidence that bail bondsmen have historically been afforded immunity for their actions." 678 F.3d 333, 340–41 (4th Cir. 2012). Conversely, in *Estate of Lockett ex rel. Lockett v. Fallin*, the Tenth Circuit held that a private contractor who performed an execution could assert qualified immunity because "he was a private party hired to do a job for which a permanent government employee would have received qualified immunity." 841 F.3d at 1109. And in *Franco v. Board of County Commissioners*, the same court held that an "independently contracted probation officer" could raise qualified immunity because "immunity under § 1983 should not vary depending on whether an individual working for the government does so as a full-time employee, or on some other basis." 609 F. App'x 957, 959 (10th Cir. 2015) (Gorsuch, J.) (quoting *Filarsky*, 566 U.S. at 1665).

With respect to public policy, lower courts disagree about whether policy considerations can justify extending immunity to private actors even in the absence of an established common-law tradition. *See, e.g.*, *McCullum*, 693 F.3d at 700 n.7 (raising the question "whether . . . a court [could] extend qualified immunity where there was no history of immunity at common law, even if sound policy justified the extension"). Some courts have held that qualified

immunity is available to private actors only when history and policy *both* favor it. *See, e.g.*, *Hughes v. Long*, 242 F.3d 121, 127 n.3 (3d Cir. 2001) (concluding that "public policy" is "an insufficient basis" for granting immunity). But others (including the Tenth Circuit) understand the history-and-policy standard to be "a disjunctive test," whereby policy *alone* can suffice. *Tanner v. McMurray*, 989 F.3d 860, 867 (10th Cir. 2021).

As the Sixth Circuit observed, this disagreement stems from perceived tension between this Court's precedents: "*Wyatt*'s plain language points to a conjunctive test," but *Richardson*, which "analyzed policy concerns, even after concluding that 'history [did] not provide significant support for the [defendants'] immunity claim,'" arguably cuts the other way. *McCullum*, 693 F.3d at 700 n.7 (alterations in original) (quoting *Richardson*, 521 U.S. at 407); *cf. also Developments in the Law – State Action and the Public/Private Distinction*, *Private Party Immunity from Section 1983 Suits*, 123 HARV. L. REV. 1266, 1271 (2010) ("*Richardson* never explained whether policy and history form a conjunctive or disjunctive test, instead leaving their roles uncertain."). This methodological disagreement has not yet proven dispositive in doctor cases, as courts have (conveniently) found either that both considerations favor immunity or that neither consideration does. *See supra* at 13–17. But it has vast implications for the availability of immunity for private actors more broadly. *See, e.g.*, *Meadows v. Rockford Hous. Auth.*, 861 F.3d 672, 677–78 (7th Cir. 2017) (holding that employees of a private security firm could assert

qualified immunity solely on the basis of policy concerns, without analyzing the common law).

4. This case is an ideal vehicle for this Court to resolve the split regarding the availability of qualified immunity for private medical personnel and, in so doing, provide sorely needed guidance about the interaction of *Wyatt*, *Richardson*, and *Filarsky*. The question whether private prison doctors like Dr. Tubbs are entitled to assert qualified immunity was fully briefed below. Pet.App.10a–15a, 55a–60a. The Tenth Circuit definitively answered it in a detailed opinion. *Id.* at 10a–15a. And its opinion squarely acknowledged contrary rulings from four other circuits. *Id.* at 14a–15a & n.2.

Moreover, the District Court found that a jury should get to decide "whether Dr. Tubbs' failure to implement protocol and training" caused a deprivation of Madison's "constitutional rights." *Id.* at 59a. So if this Court grants certiorari and holds that Dr. Tubbs is not entitled to invoke qualified immunity—the only basis for interlocutory appellate jurisdiction below,[4] *see Mitchell v. Forsyth*, 472 U.S. 511, 530 (1985)—her Estate's § 1983 claim against Dr. Tubbs will proceed to trial.

[4] *See* Pet.App.8a ("[W]hen the district court denies qualified immunity to a public official, that decision is immediately appealable when it involves an abstract issue of law[.]"); Opening Br. of Appellant Tubbs at 8–9, *Est. of Jensen*, 989 F.3d 848 (No. 20-4025), 2020 WL 3833304, at *8–10 (asserting only the denial of qualified immunity as the basis for interlocutory appellate jurisdiction).

III. THE TENTH CIRCUIT'S DECISION WAS WRONG.

This Court has made clear that private actors may invoke qualified immunity—in contravention of § 1983's plain text—only if similarly situated public employees could historically have done so. As every Court of Appeals to consider the question has recognized, state medical personnel were *not* entitled to immunity at common law. Accordingly, private actors like Dr. Tubbs cannot invoke qualified immunity today. The Tenth Circuit's contrary approach neglects the historical analysis this Court's precedents require, and is premised on a misreading of *Filarsky*. In addition, policy considerations—which cannot justify an extension of immunity in the absence of historical support—disfavor immunity, too.

1. The "question of the scope of a[n individual's] immunity from liability under § 1983 is essentially one of statutory construction." *Owen*, 445 U.S. at 635; *see also Malley v. Briggs*, 475 U.S. 335, 342 (1986) ("[O]ur role is to interpret the intent of Congress in enacting § 1983, not to make a freewheeling policy choice[.]"). Accordingly, "the starting point" for any immunity analysis "must be the language of the statute itself." *Owen*, 445 U.S. at 635. Section 1983 provides that "[*e*]*very person*" who violates the Constitution under color of state law "shall be liable" (emphasis added). "Its language is absolute and unqualified; no mention is made of any privileges, immunities, or defenses that may be asserted." *Owen*, 445 U.S. at 635.

Despite § 1983's unqualified language, this Court has "recognized that substantive doctrines of privilege and immunity may limit the relief available in § 1983

litigation." *Tower v. Glover*, 467 U.S. 914, 920 (1984).[5] But it has never asserted the power to create *new* immunities that did not already exist in 1871. It has simply recognized that § 1983 "gives no clear indication that Congress meant to abolish wholesale all common-law immunities." *Pierson v. Ray*, 386 U.S. 547, 554 (1967). Accordingly, where "a tradition of immunity was . . . firmly rooted in the common law and was supported by . . . strong policy reasons," this Court has presumed that "Congress would have specifically so provided had it wished to abolish the doctrine." *Owen*, 445 U.S. at 637. But where such a tradition does not exist, the statutory text controls and immunity is unavailable. *See Wyatt*, 504 U.S. at 164–65; *Richardson*, 521 U.S. at 403.

Consistent with these principles, this Court held in *Wyatt* that private actors are entitled to invoke qualified immunity only if similarly situated individuals "were shielded from tort liability when Congress enacted the Civil Rights Act of 1871" *and*

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[5] Some Justices have rightly questioned whether that ruling was correct in the first instance, and suggested that the doctrine of qualified immunity should be reconsidered. *See, e.g.*, *Hoggard v. Rhodes*, No. 20-1066, slip op. 1, 3 (U.S. July 2, 2021) (Thomas, J., respecting the denial of certiorari) (noting that qualified immunity "cannot be located in § 1983's text and may have little basis in history" and suggesting, as a result, that the Court "reconsider . . . the judicial doctrine" altogether); *Baxter v. Bracey*, 140 S. Ct. 1862, 1862–65 (2020) (Thomas, J., dissenting from denial of certiorari) (similar). The Court not need reach that question in this case, because private physicians like Dr. Tubbs are not entitled to qualified immunity even if such immunity is generally available to government officials. But doubts regarding the viability of the doctrine are all the more reason to cabin its reach.

policy considerations support immunity. 504 U.S. at 164. *Wyatt* was clear, moreover, that the history-and-policy standard is conjunctive. *See id.* (framing policy as an "[a]dditional[ ]" requirement that applies "irrespective of the common law support"); *id.* at 165 ("Even if there were sufficient common law support to conclude that respondents . . . should be entitled to a good faith defense, that would still not entitle them to . . . qualified immunity." (emphasis removed)). And this Court applied the same conjunctive standard in *Richardson* and *Filarsky*. *See Richardson*, 521 U.S. at 403 ("[T]his Court . . . accord[s] immunity where a 'tradition of immunity was so firmly rooted in the common law *and* was supported by such strong policy reasons that "Congress would have specifically so provided had it wished to abolish the doctrine."'" (emphasis added) (quoting *Wyatt*, 504 U.S. at 164)); *Filarsky*, 566 U.S. at 384 (explaining that the availability of qualified immunity turns both on "common law, *and* [on] the reasons we have afforded protection from suit under § 1983" (emphasis added)).

Consistent with this conjunctive standard, policy alone cannot justify the extension of immunity to a private actor; a common-law tradition is strictly required. And here, every Court of Appeals to have considered the question has recognized that, at common law, medical personnel working for the state were not immune from suit. *See Clark*, 865 F.3d at 550–51; *McCullum*, 693 F.3d at 702–04; *Lane County*, 222 F.3d at 577; *Hinson*, 192 F.3d at 1345–46; *supra* at 13–15. That should be dispositive. Because medical personnel were not "shielded from tort liability when Congress enacted the Civil Rights Act of 1871," *Wyatt*, 505 U.S. at 164, neither is Dr. Tubbs.

2. The Tenth Circuit's "historical" approach, which asks whether a publicly employed medical professional could assert qualified immunity *today*, is wrong.

For starters, Tenth Circuit's approach is irreconcilable with this Court's precedents. *Wyatt* squarely held that immunity is available only if the defendant would have been "shielded from tort liability when Congress enacted the Civil Rights Act of 1871." *Id.*; *see id.* at 164–67 (looking to history). *Richardson* said the very same thing. 521 U.S. at 403; *see also id.* at 404–07 (looking to history). And *Filarsky* looked to history, too. *See* 566 U.S. at 384–89.

The Tenth Circuit, however, made no attempt to examine the common law as it stood in 1871. Instead, it held that "common law principles support Dr. Tubbs' ability to raise a qualified-immunity defense" because "he would have certainly been able to raise [that] defense" if he had "been working as a doctor for the county on a full-time basis" today. Pet.App.11a–12a. The careful historical analysis that this Court has consistently undertaken in deciding whether to extend immunity to private actors under § 1983 is wholly absent from the Tenth Circuit's opinion.

The Tenth Circuit's approach is also internally incoherent. The court *said* that it was "[b]eginning with history." *Id.* at 11a. But its so-called historical analysis started and ended with the proposition that Dr. Tubbs would have been entitled to raise an immunity defense if he had been working for the county full time. *Id.* There is nothing "historical" about that approach. Indeed—and as this case

demonstrates—it results in the creation of new immunities unheard of in 1871. *See Tanner*, 989 F.3d at 867–68 ("No circuit that has considered this issue has uncovered a common law tradition of immunity for full-time private medical staff working under the color of state law.").

To be sure, this Court "ha[s] diverged to a substantial degree from the historical standards" of immunity "[i]n the context of qualified immunity for public officials." *Wyatt*, 504 U.S. at 170 (Kennedy, J., concurring); *see also Anderson v. Creighton*, 483 U.S. 635, 645 (1987) ("*Harlow* [*v. Fitzgerald*, 457 U.S. 800 (1982)] . . . completely reformulated qualified immunity along principles not at all embodied in the common law . . . ."). But "whether or not it was appropriate for the Court in *Harlow* to depart from history" in the context of public officials, *Wyatt*, 504 U.S. at 171 (Kennedy, J., concurring), it does not follow that this Court should "extend that approach to other contexts." *Id.*; *see also supra* at 28 n.5. In assessing immunity defenses asserted by private individuals, this Court has consistently embraced history as dispositive. *See Wyatt*, 504 U.S. at 164–67; *Richardson*, 521 U.S. at 404–07; *Filarsky*, 566 U.S. at 384–89.

3. *Filarsky* does not support the Tenth Circuit's rule. That case presented the question whether a private attorney hired by the government to investigate an employee's claim for sick leave could assert qualified immunity. 566 U.S. at 380–81. In answering that question, the Court took as a given that state employees performing the "the sort of investigative activities at issue" would have been immune from suit at common law. *See id.* at 384. The

only historical analysis the Court thus undertook was about whether, in 1871, a defendant's status as a private individual would have affected his entitlement to immunity. *See id.* at 384–89. After finding that common law did not distinguish between public and private actors in similar law-enforcement contexts, the Court held that the defendant was entitled to immunity. *Id.* at 389.

Here, by contrast, it is clear that no immunity existed for the activity Tubbs performed at the time Congress passed § 1983. *See Clark*, 865 F.3d at 550–51; *McCullum*, 693 F.3d at 702–04; *Lane County*, 222 F.3d at 577; *Hinson*, 192 F.3d at 1345–46; *supra* at 13–15. So *Wyatt*, *Richardson*, and *Filarsky* compel the conclusion that no such immunity exists today—regardless whether other precedents support a different, ahistorical result for full-time public employees performing a similar function. Indeed, this Court embraced exactly that distinction between private and public employees in *Richardson*. 521 U.S. at 407 (finding that "[h]istory . . . d[id] not provide significant support for the immunity claim" of employees of a private prison, even though their publicly employed counterparts could assert qualified immunity).

Reading *Filarsky* more broadly, such that private contractors are entitled to immunity whenever their modern public counterparts are, would effectively overrule both *Wyatt*, 504 U.S. at 164 and *Richardson*, 521 U.S. at 403. And *Filarsky* could hardly have been clearer that it did no such thing. *See* 566 U.S. at 392 ("Our decisions in *Wyatt* . . . and *Richardson* . . . are not to the contrary.").

4. Finally, although courts need not consider policy in the absence of historical support, policy also disfavors immunity for private prison doctors.

First, avoiding "unwarranted timidity," "the most important" policy consideration in immunity cases, is not a serious concern for medical professionals. *Richardson*, 521 U.S. at 400. Indeed, doctors are much more likely to face a § 1983 suit for failing to act than for acting too aggressively. *See Tanner*, 989 F.3d at 869. This dynamic—as the Tenth Circuit simply failed to recognize (despite its manifestation in Madison's own case)—distinguishes doctors from "police officers and prison guards, who rarely face liability for, as an example, not using enough force." *Id.*

Second, "talented candidates" will "not [be] deterred by the threat of damages suits from entering public service," because—as the Tenth Circuit again failed to recognize—§ 1983 exposes medical professionals to less liability than ordinary malpractice suits. *Richardson*, 521 U.S. at 411. In private settings, doctors are usually liable for malpractice if they are merely negligent. *See* RESTATEMENT (THIRD) OF TORTS: PHYS. & EMOT. HARM § 41, cmt. h (2012) ("[T]he physician's duty to the patient . . . encompasses . . . the ordinary duty not to harm the patient through negligent conduct[.]"). Liability under § 1983, by contrast, typically requires recklessness or specific intent. *See, e.g.*, *Farmer v. Brennan*, 511 U.S. 825, 835 (1994) ("Eighth Amendment liability" for deliberate indifference "requires 'more than ordinary lack of due care for the prisoner's interests or safety.'"). So there is no reason to think that the possibility of liability under § 1983 will deter doctors from working in public settings.

Third, and for similar reasons, § 1983 lawsuits will not significantly "distract" medical personnel "from their duties." *Richardson*, 521 U.S. at 411 (cleaned up). Since doctors face at least as much risk of malpractice lawsuits in private practice, they are not likely to be meaningfully distracted by § 1983 suits arising from their work in state prisons or mental-health facilities. In any event, "the risk of 'distraction' alone cannot be sufficient grounds for an immunity." *Id.*

In the end, extending qualified immunity to private medical professionals furthers no clear policy objective. To the contrary, it undermines both the text and purpose of § 1983 by leaving families like the Jensens without recourse against the doctor ultimately responsible for the tragic and unnecessary death of their daughter.

CONCLUSION

The petition for a writ of certiorari should be granted.

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