No. 21-152

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

REPLY IN SUPPORT OF CERTIORARI

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTRODUCTION 1

ARGUMENT 2

I. THE COURTS OF APPEALS ARE DEEPLY DIVIDED 2

II. THE QUESTION PRESENTED IS IMPORTANT 6

III. THE TENTH CIRCUIT'S MINORITY RULE IS WRONG 7

CONCLUSION 11

TABLE OF AUTHORITIES

Page(s)

CASES

Benjamin v. Galeno,
415 F. Supp. 2d 254 (S.D.N.Y. 2005) 10

City of Canton v. Harris,
489 U.S. 378 (1989) 7

Davis v. Buchanan Cnty.,
— F.4th —, 2021 WL 3729050
(8th Cir. Aug. 24, 2021) ..... *passim*

Democratic Nat'l Comm. v. Wis. State Legislature,
141 S. Ct. 28 (2020) 9

Est. of Clark v. Walker,
865 F.3d 544 (7th Cir. 2017) 2, 5, 7

Est. of Lockett ex rel. Lockett v. Fallin,
841 F.3d 1098 (10th Cir. 2016) 9

Estelle v. Gamble,
429 U.S. 97 (1976) 11

Filarsky v. Delia,
566 U.S. 377 (2012) 3, 4, 8

Freeman v. Fairman,
916 F. Supp. 786 (N.D. Ill. 1996) 11

Hinson v. Edmond,
192 F.3d 1342 (11th Cir. 1999) 3, 5

Jensen v. Lane Cnty.,
222 F.3d 570 (9th Cir. 2000) 2, 5, 6

TABLE OF AUTHORITIES
(continued)

Page(s)

Knight v. Grossman,
No. 16-CV-1644, 2019 WL 1298569
(E.D. Wis. Mar. 21, 2019) 5

Lee v. Willey,
543 F. App'x 503 (6th Cir. 2013) 6

McCullum v. Tepe,
693 F.3d 696 (6th Cir. 2012) 2, 5, 6, 8

Owen v. City of Indep.,
445 U.S. 622 (1980) 8

Perniciaro v. Lea,
901 F.3d 241 (5th Cir. 2018) 3

Richardson v. McKnight,
521 U.S. 399 (1997) 4, 5, 8, 10

Sanchez v. Oliver,
995 F.3d 461 (5th Cir. 2021) 4, 6

Tanner v. McMurray,
989 F.3d 860 (10th Cir. 2021) 3, 6, 9

West v. Atkins,
487 U.S. 42 (1988) 10

Wyatt v. Cole,
504 U.S. 158 (1992) 1, 8

STATUTES

42 U.S.C. § 1983 ..... *passim*

INTRODUCTION

This should be a straightforward grant. The Courts of Appeals are deeply divided about whether private medical personnel working in correctional or mental-health facilities can assert qualified immunity.[1] That split—which the Tenth Circuit acknowledged below—has deepened even since this petition was filed. Respondent's Opposition only underscores that this issue is recurring and important. The decision below is wrong. And Respondent makes no attempt to argue that this case is anything other than an ideal vehicle.

In opposing certiorari, Respondent makes two primary arguments. Both miss their mark. *First*, Respondent tries to explain away the division of authority by pointing out that the Courts of Appeals are all purporting to apply the history-and-policy test this Court endorsed in *Wyatt v. Cole*, 504 U.S. 158 (1992), and its progeny. But Respondent ignores their deep disagreement about how that test works and how it applies to private medical personnel. The fact of the matter is that Dr. Tubbs would not be able to invoke qualified immunity in five circuits; in two, he can. And Respondent's attempt to reconcile the circuits' disparate approaches by proposing his own standard—which turns on whether the defendant is employed by a large, for-profit corporation, Opp. 10–11—falls flat. Respondent's proposed standard does not track the reasoning of most courts, does not account for decisions denying immunity to employees of smaller or

[1] Contrary to Respondent's suggestion, Opp. i, n.1, the Question Presented, circuit split, and arguments in support of certiorari are limited to private actors.

non-profit outfits, and has no basis in this Court's precedents.

Second, Respondent doubles down on the Tenth Circuit's policy analysis, insisting that qualified immunity is necessary to protect prison healthcare providers, particularly in rural and under-resourced areas. Notably, however, Respondent identifies no historical precedent for extending qualified immunity to private medical personnel. And his suggestion that qualified immunity can be justified on policy alone is irreconcilable both with the text of § 1983 and with this Court's prior rulings. Respondent gets the policy calculus wrong in any event. There is no good reason to believe that private medical personnel will be any more deterred or distracted by § 1983 lawsuits than they are by ordinary malpractice suits. And there is every reason to believe that extending qualified immunity will leave people like Madison without a remedy for violations of their constitutional rights.

This Court should grant certiorari, reverse the decision below, and allow the Estate's claim to proceed on the merits.

ARGUMENT

I. THE COURTS OF APPEALS ARE DEEPLY DIVIDED.

A. In the decision below, the Tenth Circuit recognized what was then a four-to-two split among the Courts of Appeals. *See* Pet.App.14a n.2; Pet. 13–17. The Tenth Circuit disagreed with those circuits holding that "qualified immunity is not available to a private medical professional providing services to a jail." Pet.App.14a n.2 (citing *McCullum v. Tepe*, 693 F.3d 696, 704 (6th Cir. 2012); *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); *Hinson v. Edmond*, 192 F.3d 1342, 1347 (11th Cir. 1999), *amended*, 205 F.3d 1264 (11th Cir. 2000)). Instead, it endorsed the Fifth Circuit's contrary "read[ing] [of] *Filarsky*" *v. Delia*, 566 U.S. 377 (2012), and held that private medical personnel like Dr. Tubbs can invoke qualified immunity. Pet.App.15a (quoting *Perniciaro v. Lea*, 901 F.3d 241, 252 n.9 (5th Cir. 2018)).

B. That divide has only deepened in the six weeks since this petition was filed. In *Davis v. Buchanan County*, — F.4th —, 2021 WL 3729050 (8th Cir. Aug. 24, 2021), the Eighth Circuit faced a set of facts tragically similar to those of Madison's case. *Id.* at *1 ("Justin A. Stufflebean died after allegedly being denied necessary medication" just six days after entering custody). And it joined the Sixth, Seventh, Ninth, and Eleventh Circuits in holding that "employees of private medical-services-providers" "are not entitled to assert the defense of qualified immunity." *Id.* at *4–5. In so doing, the Eighth Circuit found that neither history nor policy supported extending immunity to private medical personnel. *Id.* at *5–10. On history, the court—like "[a]ll other circuits" to have considered the question—found no "firmly rooted tradition of immunity" for those actors. *Id.* at *5; *see also id.* at *6 (recognizing that *Filarsky* "did not abandon the need for particularized historical analysis"). And on policy, the court reasoned, among other things, that "[p]rivate medical personnel … may be uniquely equipped to handle … litigation distractions" because they already "'face a constant threat of claims leading to litigation.'" *Id.* at *7–9 (quoting *Tanner v. McMurray*, 989 F.3d 860, 870 (10th Cir. 2021)).

C. Respondent's attempts to minimize this entrenched split, *see* Opp. 5–21, are unavailing.

1. Respondent primarily argues that there is no real split because the Courts of Appeals all apply a two-part history-and-policy test derived from *Richardson v. McKnight*, 521 U.S. 399 (1997), and *Filarsky*. *See, e.g.*, Opp. 10 ("Consistent with *Richardson* and *Filarsky*, the Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, and Eleventh Circuit[s] … have each engaged in a two-part analysis in deciding whether a private medical provider could assert a qualified immunity defense."). That is true, insofar as it goes. Indeed, the Courts of Appeals actually agree on how the historical part of that test shakes out: "[A]ll … circuits to have considered the issue have found no compelling history of immunity for private medical providers in a correctional setting." *Sanchez v. Oliver*, 995 F.3d 461, 468 (5th Cir. 2021); Pet. 18; Opp. 11–18, 24–25.

Where the circuits have split is with respect to whether policy alone can support an extension of immunity—and, as a result, whether private medical personnel are entitled to claim it. *See* Pet. 13–17, 25–26, 29. On the one hand, five circuits have held, relying primarily on *Richardson*, that qualified immunity is unavailable to private medical personnel because neither history nor policy supports its application in that context. *See id.* at 13–15; *Davis*, 2021 WL 3729050, at *5–10. On the other, two circuits have held, relying primarily on *Filarsky*, that some such personnel may claim immunity based on policy arguments alone. Pet. 15–17.

2. Respondent only confuses matters further by suggesting that the dispositive question should be whether the defendant works for a "private firm[] systematically organized to assume a major lengthy administrative task … for profit" and "with limited direct supervision by the government." Opp. 10, 14, 21–22. For starters, that standard—apparently drawn from the Eighth Circuit's recent ruling in *Davis* and selective quotes from *Richardson*—bears no clear relationship to the "two-part analysis" that Respondent elsewhere correctly identifies as the governing standard. *See, e.g.*, *id.* at 10–16, 18, 21–24.

In any event, Respondent's proposed standard does not reflect the majority rule. The Sixth, Seventh, Ninth, and Eleventh Circuits have all rejected qualified immunity for private medical personnel in categorical terms. *See* Pet. 13–15 (discussing *McCullum*, *Clark*, *Lane County*, and *Hinson*). District courts in those circuits understand the rule against qualified immunity for prison medical personnel to be categorical. *See, e.g.*, *Knight v. Grossman*, No. 16-CV-1644, 2019 WL 1298569, at *6 (E.D. Wis. Mar. 21, 2019) ("The Seventh Circuit has held … that private medical personnel in prisons are not afforded qualified immunity."), *aff'd*, 942 F.3d 336 (7th Cir. 2019). And Respondent cites no case from those circuits suggesting that some different rule applies to sole proprietors or smaller practices.

To the contrary, many decisions from those circuits involve defendants who were *not* employed by "large firms that are systematically organized to perform a major administrative task for profit." Opp. 10 (quoting *Davis*, 2021 WL 3729050, at *9). In *McCullum*, for example, the defendant worked for "an

independent *non-profit* organization." 693 F.3d at 699 (emphasis added). And in *Lane County*, the defendant was described as "a contract psychiatrist" who was "affiliated with a private group." 222 F.3d at 573; *see also, e.g.*, *Lee v. Willey*, 543 F. App'x 503, 503, 505–06 (6th Cir. 2013) (denying qualified immunity to a psychiatrist hired by the state through a recruiting agency to work "as a private contractor").

To be sure, the Fifth, Eighth, and Tenth Circuits have sometimes suggested that the size or structure of the medical professional's employer may be relevant to the qualified immunity analysis. *See Sanchez*, 995 F.3d at 467; *Davis*, 2021 WL 3729050, at *9; *Tanner*, 989 F.3d at 874. But even assuming those three courts could be understood to have adopted a rule that hinges on that fact, it makes no difference here. The circuits are still split, given that at least four have endorsed a bright-line rule that applies regardless the size or structure of the defendant's employer. *See supra* at 5–6. And that split is still outcome determinative with respect to Petitioner's claim against Dr. Tubbs, a solo practitioner who would not be entitled to invoke qualified immunity in the majority of circuits.

II. THE QUESTION PRESENTED IS IMPORTANT.

There can be little doubt that the availability of qualified immunity for private medical personnel is enormously consequential for jails and detainees alike. Pet. 19–26. Respondent concedes that correctional facilities increasingly rely on private doctors and psychiatrists to care for detainees and prisoners. *See* Opp. 26; Pet. 19–20. Respondent recognizes that the prison population is "aging," "vulnerable," and "health-compromised." Opp. 23, 26.

And Respondent does not dispute that qualified immunity, if available, will very often bar otherwise meritorious constitutional claims. *See* Pet. 21.

Respondent's argument about rural and poor counties, Opp. 22–23, only highlights the importance of this issue. "[S]mall rural counties," Respondent contends, often lack the resources to "hire, train, and supervise doctors and nurses in the particular demands that their facilities require." *Id.* Accordingly, he claims that denying qualified immunity to private medical providers would hinder rural jails "from obtaining health care services for [their] inmates." *Id.* at 22. The fairly shocking implication that a lack of training and supervision should *excuse* constitutional violations gets the law exactly backwards. *Cf. City of Canton v. Harris*, 489 U.S. 378, 388 (1989) ("[A] city can be liable under § 1983 for inadequate training of its employees."). But what matters for present purposes is that Respondent appears to agree that the answer to the Question Presented really matters.

III. THE TENTH CIRCUIT'S MINORITY RULE IS WRONG.

A. Every circuit to have considered the question has concluded 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." *Est. of Clark*, 865 F.3d at 550–51; *see also* Pet. 13–17; *Davis*, 2021 WL 3729050, at *5 ("The first factor—the historical availability of immunity—does not support these medical defendants asserting qualified immunity."); *see id.* (noting that "[a]ll other circuits" agree). Respondent makes no serious

argument to the contrary and, indeed, cites no historical authority whatsoever. Instead, Respondent conclusorily asserts that the Tenth Circuit's reasoning that Dr. Tubbs could have asserted immunity if he worked "for the County on a full-time basis" somehow "fulfill[s] the historical common law analysis addressed in *Filarsky*." Opp. 3.

Needless to say, the fact that state employees would be entitled to invoke immunity *today* does not establish a historical tradition of immunity for private doctors like Tubbs. And the absence of historical support for immunity in this context should be dispositive. Consistent with *Wyatt*, *Richardson*, and *Filarsky*, private actors can invoke qualified immunity notwithstanding § 1983's unqualified language only "if the 'tradition of immunity was … firmly rooted in the common law *and* was supported by … strong policy reasons.'" *Wyatt*, 504 U.S. at 163–64 (quoting *Owen v. City of Indep.*, 445 U.S. 622, 637 (1980)) (emphasis added); *see also Richardson*, 521 U.S. at 404 (*Wyatt* "tell[s] us … to look *both* to history *and* to the purposes that underlie government employee immunity" (emphasis added)); *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)). The test, in other words, is "conjunctive." *McCullum*, 693 F.3d at 700 n.7; *see* Pet. 28–30. And this Court has *never* held that qualified immunity is availability to private actors in the absence of a historical tradition.

B. Although Respondent at times purports to embrace history, *see* Opp. 5–6, 10–12, 14, 25, he ultimately endorses the Tenth Circuit's "disjunctive

test," *id.* at 17 (quoting *Tanner*, 989 F.3d at 867). In Respondent's and the Tenth Circuit's view, "[p]rivate individuals are entitled to assert qualified immunity if their claim is supported by historical practice *or* based on public policy considerations." *Id.* (quoting *Tanner*, 989 F.3d at 867) (citation omitted) (emphasis added). So "public policy analysis" alone can be "sufficient to extend the qualified immunity defense to a private actor." *Id.* at 26 (discussing *Est. of Lockett ex rel. Lockett v. Fallin*, 841 F.3d 1098 (10th Cir. 2016)).[2]

The notion that courts can create new immunities unheard of at common law has no basis in § 1983's text. *See* Pet. 4–5, 27–28. It is inconsistent with this Court's precedents. *See id.* at 5–6, 29–30; *supra* at 8. And it confuses judges (who interpret and apply the law) with lawmakers (who "make policy and bring to bear the collective wisdom of the whole people when they do"). *See Democratic Nat'l Comm. v. Wis. State Legislature*, 141 S. Ct. 28, 29 (2020) (Gorsuch, J., concurring). Congress is certainly free to determine that private medical personnel working in correctional or mental-health facilities ought enjoy qualified immunity from suits under § 1983. Absent such legislation, courts should not extend qualified immunity to new classes of private actors.

C. In any event, policy considerations cut against extending immunity to private medical personnel

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[2] Respondent makes much of the fact that this Court denied certiorari in *Lockett*. Opp. 25, 26. But the *Lockett* petition was about the application of the Eighth Amendment to claims based on execution by lethal injection. *See* Pet., *Lockett v. Fallin*, 137 S. Ct. 2298 (2017) (No. 16-1255), 2017 WL 1422434. It did not present the question whether private medical personnel are entitled to qualified immunity.

working in public correctional facilities. *See* Pet. 33–34; *Richardson*, 521 U.S. at 407–12 (considering the risks of creating "unwarranted timidity," deterring "talented candidates," and "distracting" workers from their duties). "Unwarranted timidity" is unlikely, including because medical professionals have an independent ethical obligation to promote their patients' well-being. *Cf. West v. Atkins*, 487 U.S. 42, 51 (1988) (doctor had "professional and ethical obligation to make independent medical judgments"). Indeed, nearly every case at issue here arose from an alleged *failure* to provide necessary medical services. *See, e.g.*, Pet.App.18a (claim based on "failure to secure medical treatment"); *Davis*, 2021 WL 3729050, at *1 (detainee allegedly "denied necessary medication"). Moreover, medical professionals are unlikely to be "deterred" or "distracted" by the threat of § 1983 liability because they are already subject to malpractice suits for mere negligence. *Cf., e.g.*, *Benjamin v. Galeno*, 415 F. Supp. 2d 254, 256 (S.D.N.Y. 2005) ("Malpractice claims cannot be brought under Section 1983, because they sound in negligence, and mere negligence does not rise to the level of a constitutional tort.").

Respondent offers no sound policy argument to the contrary. He identifies no problems that have arisen in the majority of jurisdictions that do not extend qualified immunity to private medical personnel. He offers no reason to fear unwarranted timidity in the absence of such immunity. And he fails to explain why exposure to liability for Eighth Amendment violations is any more problematic than exposure to malpractice claims in private practice. After all, "[t]he 'deliberate indifference' required by the Eighth Amendment is a

standard higher than simple negligence." *Freeman v. Fairman*, 916 F. Supp. 786, 791 (N.D. Ill. 1996). Moreover, any limitations on insurance coverage for intentional acts, Opp. 26, presumably apply in private settings, too.

In the end, Respondent's position appears to rest primarily on the propositions that medical personnel may not wish to be sued by "an inmate or inmate's family," *id.*, and that some correctional facilities struggle to provide inmates with adequate medical care, *see id.* at 22–23. Both are likely true. But neither trumps the Eighth Amendment's guarantee against "deliberate indifference to serious medical needs of prisoners." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

CONCLUSION

The petition should be granted.

September 17, 2021

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