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22 AMICUS CURIAE AFSCME, LOCAL 2620

23 UNITED STATES DISTRICT COURT  
24 NORTHERN DISTRICT OF CALIFORNIA

25 MARCIANO PLATA, et al.,

26 Plaintiffs,

27 v.

28 ARNOLD SCHWARZENEGGER, et al.,

Defendants.

No. C-01-1351 T.E.H.

**BRIEF OF AMICI CURIAE  
UNION OF AMERICAN PHYSICIANS  
& DENTISTS, SEIU LOCAL 1000  
(CSEA) AND AFSCME, LOCAL 2620  
ON APPOINTMENT OF RECEIVER**

UNION OF AMERICAN PHYSICIANS  
& DENTISTS; CALIFORNIA STATE  
EMPLOYEES ASSOCIATION –  
SERVICE EMPLOYEES INTERNA-  
TIONAL UNION, LOCAL 1000; and  
AMERICAN FEDERATION OF STATE,  
COUNTY AND MUNICIPAL  
EMPLOYEES, LOCAL 2620,

*Proposed Union Amici Curiae.*

DATE: June 30, 2005  
TIME: 9:00 a.m.  
DEPT.: Courtroom 12

JUDGE: Hon. Thelton Henderson

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1       **I.       INTRODUCTION**

2               The Union of American Physicians & Dentists (“UAPD”), Service Employees  
3 International Union, Local 1000 (CSEA) (“SEIU”), and American Federation of State,  
4 County and Municipal Employees, Local 2620 (“AFSCME”) thank the Court for the  
5 opportunity to present this brief. Amici share this Court’s grave concern at the level of  
6 care being provided to many inmates in California’s correctional facilities. Amici do not  
7 believe that the current management of the California Department of Corrections (“CDC”)  
8 has demonstrated the competence or capacity to address the manifold reforms necessary to  
9 provide competent care to California’s prisoners.  
10

11               Moreover, current CDC management does not have the trust of the many dedicated  
12 and competent physicians, nurses, and other licensed professionals who provide health  
13 care to this State’s prisoners. This lack of trust stems in part from CDC’s now-familiar  
14 mantra in responding to charges of mismanagement and poor care: falsely blaming its  
15 employees and their unions. Unfortunately, such was the tenor of much of the testimony  
16 at this Court’s multi-day hearing on its Order to Show Cause. Amici wish to respond to a  
17 number of unfounded assertions presented to the Court during those hearings.

18               This Court should recognize that Amici have vigorously supported nearly all of the  
19 proposals for reform forwarded by this Court’s experts. For instance, contrary to CDC’s  
20 hearing testimony, UAPD categorically supports the evaluation of CDC physicians to  
21 determine whether they are fit for service: the sole question is how best to do so. UAPD  
22 also supports the disciplining of those physicians who are negligent in providing care.  
23

24               Likewise, SEIU has long lobbied for reforms that would redress the glaring  
25 vacancy rate for RNs in the CDC system, and has proposed pay increases, better working  
26 conditions and the elimination of inappropriate custody staff supervision as means of  
27 recruiting more RNs. However, SEIU has opposed the CDC’s use of registry nurses to fill  
28 such vacancies – a practice that this Court’s experts agree is ill-advised.

1 AFSCME has also forwarded proposals designed to address the chronic shortage of  
2 healthcare professionals in the CDC system. In particular, AFSCME bargained to limit CDC's  
3 costly use of contracted-out pharmacists, social workers and psychologists, and to increase the  
4 compensation for those classifications commensurate with prevailing market levels.

5 Given CDC's proven incompetence and lack of leadership, Amici believe that the  
6 appointment of a receiver may be a necessary step to reform. However, such a receiver  
7 should recognize, as this Court's experts have, that CDC health care practitioners face  
8 unnecessary and often insurmountable hurdles in providing medical care, including  
9 inadequate facilities, antagonistic custodial officials, and unavailable medical records and  
10 laboratory results.

11 Amici are heartened by this Court's statement that it "will not empower the  
12 receiver to interfere with [the unions'] contractual rights" and that the Court intends to  
13 allow the unions to submit further briefing on the powers that should be granted to an  
14 appointed receiver. *Plata v. Schwarzenegger*, No. C-01-1351, Evidentiary Hearing  
15 Transcript, Vol. IV. 650:9-10, 651:12-13 (hereinafter, "Transcript"). This Court should  
16 seek a receiver who not only recognizes the importance of union representation and civil  
17 service protection in providing a stable, motivated workforce, but also engages CDC  
18 employees and their unions in the process of reform. Amici believe that John Hagar, the  
19 current Special Master in the *Madrid* case, is such a person and should be appointed as an  
20 interim receiver until a permanent receiver can be appointed.

21  
22 **II. APPOINTMENT OF A RECEIVER MAY BE JUSTIFIED GIVEN CDC'S**  
23 **INCOMPETENCE AND LACK OF LEADERSHIP IN ADDRESSING THE**  
24 **PROBLEMS IDENTIFIED BY THIS COURT.**

25 Clearly, appointment of a receiver is a remedy of final resort. "In evaluating  
26 whether a receivership is really the only remedy left for the Court, the court should  
27 consider whether there were repeated failures to comply with the Court's orders, whether  
28 continued insistence on compliance with the Court's orders would lead only to

1 ‘confrontation and delay,’ if there is a lack of sufficient leadership to turn the tide within a  
2 reasonable time period, whether there was bad faith, and whether resources are being  
3 wasted.” *Dixon v. Barry*, 967 F.Supp. 535, 550 (D.D.C. 1997); *see also Petitpren v.*  
4 *Taylor Sch. Dist.*, 304 N.W.2d 553, 557 (Mich. App. 1981) (receiver appropriate only  
5 when “other approaches have failed to bring compliance with a court’s orders, whether  
6 through intransigence or incompetence.”).

7  
8 **A. CDC’s Mismanagement, Not Collective Bargaining Or State Civil  
Service Protections, Has Led To The Current Predicament.**

9 CDC has defended its failure to abide by the terms of this Court’s orders or to  
10 make substantial improvements in the quality of medical care in the *Plata* institutions by  
11 pointing the finger at its employees’ unions and state civil service protections.  
12

13 However, a review of the record demonstrates that CDC’s failure to abide by this  
14 Court’s orders has been a result of its own mismanagement, rather than state civil service  
15 laws or its collective bargaining obligations.

16 **1. CDC’s failure to improve the quality of medical care is not a  
17 result of its collective bargaining obligations.**

18 Plaintiffs and CDC both appear to believe that CDC’s collective bargaining  
19 responsibilities stand in the way of the Department’s ability to effectuate reform. In fact,  
20 Amici have advocated and bargained for many of the reforms deemed necessary by this  
21 Court’s experts. CDC’s unwillingness to negotiate such reforms in the past have led to its  
22 current predicament.

23 Although this Court has made clear that it does not intend to empower any  
24 appointed receiver to override the unions’ state bargaining rights,<sup>1</sup> an appointed receiver  
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26  
27 <sup>1</sup> This Court would not have authority to do so, as an appointed receiver would be  
28 solely effectuating this Court’s entry of a consent decree in a case in which the unions have  
not been made a party. *See Local 93, Int’l Ass’n of Firefighters v. City of Cleveland*, 478 U.S.  
501 (1986); *cf. Stone v. City and County of San Francisco*, 968 F.2d 850, 861 n.20 (9th Cir.

1 would likely take CDC's place at the bargaining table. *See Dixon*, 967 F.Supp. at 555-56  
2 (receiver granted contractual and personnel power); *Reed v. Rhodes*, 500 F.Supp. 363,  
3 397-98 (same). Should it appoint a receiver, this Court should recognize the constructive  
4 role played by the unions in promoting reform and should appoint a receiver willing to  
5 work with the unions.

6 As an example of the "cumbersome" collective bargaining process standing in the  
7 way of reform, Plaintiffs and CDC cite the SEIU's grievance over CDC's use of registry  
8 nurses. Transcript, Vol. III, 432:1-5 (Hanson testimony); 482:16-19 (Duveneck  
9 testimony). However, this Court's experts have stated that the use of registry nurses is not  
10 a good substitute for actively recruiting permanent staff nurses. Transcript, Vol. I, 109:3-  
11 23 (Puisis testimony); Vol. II, 291:6-9, 293:22-24 (LaMarre testimony). SEIU's  
12 opposition to the use of registry nurses is not a hindrance to reform, but is in line with the  
13 Court experts' position.

14 SEIU has bargained for policies that would attract RNs to correctional facilities.  
15 For example, for over a year, SEIU has had a package of reform proposals on the table  
16 aimed at improving CDC's ability to recruit and retain RN's, including pay increases, a  
17 ban on unsafe, mandated overtime, and the elimination of inappropriate supervision of  
18 RNs by custody staff. Hansen Decl., ¶ 13 (attached hereto); *cf.* Transcript, Vol. II, 290:24-  
19 291:4 (CDC RN salaries 20-40% below competitors) (LaMarre testimony). CDC's  
20 response has been a scant 5% pay increase, and an additional pay increase of 5% for just  
21 189 of its 800 RNs. Hansen Decl., ¶ 3.

22 In addition, SEIU has bargained for medical technical classifications such as  
23 clinical laboratory and radiologic technologists, respiratory care practitioners, dental  
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1992) ("The respect due the federal judgment is not lessened because the judgment was entered by consent. The plaintiffs' suit alleged a denial of their constitutional rights. When *defendants chose to consent* to a judgment . . . the result was a fully enforceable federal judgment that overrides any conflicting state law or state court order.").

1 assistants and hygienists. CDC has failed to redress vacancies in these classifications in  
2 spite of the union's efforts to propose solutions at the bargaining table. Kugelmass Decl.,  
3 ¶ 2. Management has consistently failed to address the resource needs for these  
4 employees to be able to perform their jobs and provide for the health care needs of the  
5 inmates. *Id.* Employees in these classifications must have access to up-to-date equipment  
6 and online services so that care can be provided in the similar manner as current medical  
7 services settings. *Id.* CDC management has placed such a low priority in these areas that  
8 it has not committed the resources to recruit and retain qualified medical professionals and  
9 has ignored union proposals to address these issues. *Id.*

10  
11 AFSCME, Local 2620 has also submitted to CDC a series of proposals to address  
12 chronic vacancies, particularly among social workers, pharmacists, and psychologists.  
13 Nkrumah Decl., ¶ 2 (attached hereto). AFSCME has sought to limit resort to high-cost,  
14 emergency contracting-out of pharmacist and clinical social worker positions. *Id.* These  
15 proposals have generally gone unheeded. *Id.*

16 Similarly, UAPD has advocated many of the reforms now cited as necessary by the  
17 Court experts. For example, the Court experts question the competence of CDC's Internal  
18 Affairs division in investigating complaints of physician negligence. Transcript, Vol. II,  
19 349:13-350:13; Vol. III, 389:18-23 (Goldenson testimony). UAPD has lobbied for  
20 replacing Internal Affairs investigations with a system under which all serious complaints  
21 about physician competency would be investigated by a CDC management physician or  
22 dentist. Robinson Decl., ¶ 8. UAPD has also repeatedly called for a salary survey and  
23 salary increases in line with those advocated by the Court experts. Robinson Decl., ¶ 8;  
24 Transcript, Vol. I, 60:8-14 (Puisis testimony).

25  
26 In short, CDC's collective bargaining obligations cannot be scapegoated for  
27 CDC's inability to improve the quality of healthcare in California's prisons. In fact, the  
28 unions representing CDC's medical personnel have long advocated and bargained for

1 many of the reforms deemed necessary by this Court's experts. Rather than seeking to  
2 understand the needs of its employees in providing competent medical care and to support  
3 these needs with adequate resources, CDC has unilaterally pursued ineffective and stopgap  
4 solutions to chronic problems.

5  
6 **2. CDC has carried out this Court's September 2004 order in an  
unreasonable manner.**

7  
8 This Court and Plaintiffs have both expressed concern over CDC's failure to  
9 implement the competency evaluation aspect of the September 17, 2004 patient care order.  
10 CDC's reply, largely in response to Plaintiffs' line of questioning on the subject, has been  
11 that its delay in evaluating the competence of its physicians has been due to intransigence  
12 on the part of UAPD. *See, e.g.*, Transcript, Vol. III, 436:17-24 (Hanson testimony); *see*  
13 *also* Transcript, 184:3-23 (Puisis testimony).

14 In fact, UAPD categorically supports the evaluation of correctional facility  
15 physicians to determine their competence. UAPD has made this position known to both  
16 CDC and this Court. Robinson Decl., ¶ 2 (attached hereto). However, CDC chose to  
17 implement this Court's patient care order in a manner that is fundamentally  
18 counterproductive: by requiring all CDC physicians,<sup>2</sup> regardless of their credentials or  
19 demonstrated capacity for quality care, to take a standardized, computer-based  
20 examination on two weeks' notice, with two days to study, and with the prospect of being  
21 reported to the California Medical Board as an incompetent physician if they fail.  
22 Robinson Decl., ¶ 3. The QICM examination run by the University of California, San  
23 Diego ("UCSD") has never before been used for mass-testing of this nature and UCSD's  
24 analogous PACE program is used by the Medical Board only *after* there is individualized  
25 suspicion that a physician is indeed incompetent. Transcript, Vol II, 186:14-20  
26

27  
28 <sup>2</sup> CDC later unilaterally decided to exempt physicians who are Board-certified in  
Internal Medicine or Family Practice. Transcript, Vol. IV, 611:16-20 (Kanan testimony).

1 (Goldenson testimony); Vol. IV, 610:3-6 (Kanan testimony); Robinson Decl., ¶ 4.  
2 Clearly, no physician with any other job prospects would risk being reported to the  
3 Medical Board by taking a standardized examination under such circumstances.

4         Indeed, with their medical careers at stake, many of the most qualified physicians  
5 in the CDC system are leaving. Robinson Decl., ¶ 5. As this Court’s experts have made  
6 clear, the system is already severely understaffed and the State faces extreme challenges in  
7 recruiting qualified physicians. Transcript, Vol. I, 60:1-14; 97:24-25, 99:14-18 (Puisis  
8 testimony). The CDC’s approach to competency evaluation exacerbates these problems.  
9

10         Designing the outside evaluation as CDC did was not the idea of this Court’s  
11 experts, nor is it, according to those experts, the only way to identify incompetent  
12 physicians in the system. Transcript, Vol I, 34:22-23 (Puisis testimony); Vol. III, 417:8-  
13 418:8 (Goldenson testimony).<sup>3</sup> The Court experts agree that the majority of physicians in  
14 the CDC system are competent and do not need to undergo testing. Transcript, Vol. I,  
15 52:9-15; 104:1-4 (“Well, not everyone needs to be tested. Some of the doctors are  
16 competent. They have board certification, yet they are required to go to QICM.”) (Puisis  
17 testimony). However, Dr. Puisis appears to believe that QICM is necessary because CDC  
18 is otherwise unable to terminate or suspend incompetent physicians. Transcript, Vol. I,  
19 103:21-104:4; 185:8-14 (“As I said in my testimony, would one normally construct a  
20 process like QICM if you had a reasonable management staff, and the answer is no, or a  
21 reasonable personnel policy, and the answer is no, because you would be able to discipline  
22 people with the staff you had. Because you don’t, and because you have a union that  
23 opposes the firing of physicians, QICM seemed like a reasonable step to take.”).

24         In fact, UAPD does not oppose disciplining problem doctors, nor has UAPD  
25 prevented CDC from placing on administrative leave those physicians considered  
26

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27  
28 <sup>3</sup> Indeed, Dr. Goldenson does not believe that the QICM evaluation will identify most  
problem doctors. Transcript, 417:22-24.

1 incompetent by this Court's experts. Transcript, Vol. III, 290: 2-4 (Goldenson testimony);  
2 Vol. IV, Robinson Decl., ¶ 6. Physicians deemed incompetent are often suspended or  
3 terminated by CDC. Robinson Decl., ¶ 6. Use of QICM cannot be justified on this basis.  
4 Moreover, CDC has always said that it would unilaterally move forward with QICM  
5 regardless of UAPD's objections, and has done so. UAPD is not the cause of any delay.

6 When asked what a receiver should do to identify and remove incompetent physicians,  
7 Dr. Puisis stressed that such evaluation should be done on a site-by-site basis, with each  
8 physician's credentials and work history reviewed. Transcript, Vol. II, 230:21-231:7, 232:8-  
9 10; 233:20-23. Only after such *individualized scrutiny* would physicians suspected of  
11 incompetence be referred for examination of some sort. Transcript, Vol. II, 233:14-16 ("the  
12 group that did not have training would be *subject to further scrutiny* to see whether they  
13 needed to be reviewed by a program like QICM or in some other manner."). UAPD has  
14 repeatedly called for competency evaluation of exactly this nature. Robinson Decl., ¶ 2.

15 CDC adopted the QICM policy without any notice to UAPD or negotiation over  
16 the appropriate nature of competency evaluation. The General Counsel of the Public  
17 Employment Relations Board has found merit in UAPD's charge that CDC's failure to do  
18 so is in violation of state law. Robinson Decl., ¶ 7. Despite the issuance of an unfair labor  
19 practice complaint, CDC still refuses to negotiate with UAPD over whether QICM is the  
20 appropriate means of determining physician competency. Robinson Decl., ¶ 3. CDC's  
21 failure to negotiate with UAPD has resulted in a badly designed evaluation system that has  
22 alienated many competent physicians.

23 In sum, CDC's response to this Court's patient care order was to devise an  
24 evaluation system that is leading to an exodus of competent physicians, that is not  
25 expected to identify many incompetent physicians, and that eschews the individualized,  
26 site-by-site examination of physicians' work histories advocated by this Court's experts.  
27 Amici believe that it is CDC's design and implementation of the QICM program that  
28

1 demonstrates the Department's inability to carry out reform, not UAPD's opposition to  
2 that program.

3 **B. Should This Court Determine That Receivership Is Necessary, Amici**  
4 **Urge That This Court Appoint John Hagar As Temporary Receiver.**

5 As set forth above, CDC's medical personnel and their unions have an important  
6 role to play in the reform of health care services in California's prisons. This Court should  
7 appoint a receiver who recognizes the need for input from rank-and-file employees and  
8 who is willing to engage with their unions.

9 Amici support appointment of John Hagar, Special Master in the *Madrid* case, as  
10 temporary receiver until a permanent receiver can be appointed. John Hagar has  
11 demonstrated his ability improve the provision of medical care at Pelican Bay. Moreover,  
12 Hagar has earned the trust of unions representing medical personnel at that facility.

13 **III. CONCLUSION**

14 CDC has demonstrated its unwillingness to adopt reforms that would improve the  
15 physical facilities, pay and benefits, and supervisory structures affecting its physicians, nurses,  
16 pharmacists and other licensed health care professionals. Instead, it has scapegoated its  
17 employees and their unions. The appointment of a receiver may be necessary to improve the  
18 quality of medical care in California's prisons. However, an appointed receiver should  
19 recognize the role played by Amici in promoting the reforms that this Court has deemed  
20 necessary and should be committed to working with rank-and-file employees and their unions  
21 in improving medical care. Amici support this Court's proposal to allow further briefing on  
22 the scope of the receiver's powers as a first step in this process.

23 Dated: June 20, 2004

24 Respectfully submitted

25 DAVIS, COWELL & BOWE

26  
27 By: 

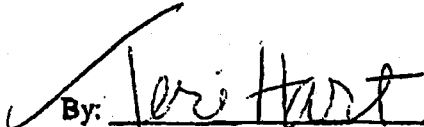
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