In the

United States Court of Appeals

For the Seventh Circuit

No. 21-1647

DANA BROWN,

Plaintiff-Appellant,

v.

KURT OSMUNDSON,
TERRY EDWARDS, and
BRITANY BEARD (MILLER),

Defendants-Appellees.

Appeal from the United States District Court for the
Central District of Illinois.
No. 17-cv-04284 — **Jonathan E. Hawley**, *Magistrate Judge*.

ARGUED JUNE 2, 2022 — DECIDED JUNE 27, 2022

Before EASTERBROOK, ST. EVE, and JACKSON-AKIWUMI, *Circuit Judges*.

ST. EVE, *Circuit Judge*. Dana Brown, a prisoner in the Illinois River Correctional Center, started to feel some abdominal pain. A few days later, he told the prison's nurse practitioner about his symptoms, who prescribed some pain medicine. Brown then returned to his cell, but the pain

became more severe. Brown was taken to the prison's infirmary, where the prison's nurses and doctor treated him over three-and-a-half days. Despite the treatment, the symptoms worsened, and Brown needed to be transported to a hospital. There, he was diagnosed with appendicitis, which required surgery to remove his appendix.

Brown sued three of the officials who cared for him in the prison's hospital, alleging violations of his Eighth Amendment rights. The district court granted summary judgment for the defendants. We affirm. The prison medical staff did not act with the necessary deliberate indifference, a high bar under current precedent, toward Brown's serious medical condition.

I. Background

While working in the prison's bakery on February 20, 2017, Brown began experiencing abdominal pain, which he attributed to a preexisting hernia. The next day though, the pain had worsened. He could not bend down to take bread out of the oven, needing to rely on his coworker to cover his work. By the end of his shift, Brown was sweating profusely, was unable to leave his bed, and had to use a jug in his cell to urinate. Despite the pain, Brown decided to wait to consult medical personnel for two days, when he went to see Nurse Practitioner Britany Miller for an appointment he previously scheduled before his abdominal pain began.

At the appointment, Brown reported "back pain [at] nine out of ten on the pain scale with groin discomfort." N.P. Miller believed that Brown had a problem with his right hernia. She prescribed some Ibuprofen, a hernia belt, and a "no work" permit for three days. Brown returned to his cell and

did not leave his bed for two days; during this time, he eventually stopped drinking and eating altogether. On the night of February 25, Brown asked for help, and the guards took him to the medical wing.

Nurse Terry Edwards saw Brown upon his arrival. Brown could not stand, was clutching his abdomen, complained of constant stabbing pain, which was a "ten out of ten," and had an elevated blood pressure. His abdomen was "swollen and tender to the touch." Nurse Edwards called Dr. Kurt Osmundson, who ordered that Brown be given an injection of pain medication, which did little to dull the pain, and placed him on 23-hour observation. The next day, a non-defendant nurse saw Brown, who still suffered from abdominal pain, and called Dr. Osmundson to report his condition. Dr. Osmundson formally admitted Brown to the infirmary and ordered a urinalysis, vital checks, and Motrin three times a day. On February 27, two days after Brown entered the prison's medical wing, Dr. Osmundson examined Brown in-person and detected positive bowel sounds. He ordered an x-ray, regular vital checks, a painkiller, diet and activities as tolerated, an Accu-Chek, a blood count, a metabolic panel, and another urinalysis.[1]

Brown's pain subsided briefly later that day, but by the evening, it had returned. Brown called for a nurse as he continued to vomit throughout the night in increasingly worrisome colors, such as "bright yellow with … brown colored flecks," and his blood pressure started to spike. At midnight, one nurse observed that Brown's abdomen appeared hard to

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[1] Brown alleges, in his deposition, that N.P. Miller returned to work and "refused" to see Brown during this time.

the touch. Early the next morning, on February 28, Nurse Edwards called Dr. Osmundson to report these symptoms. Six hours later, Dr. Osmundson saw Brown, who was in considerable pain but whose blood and urine tests returned essentially to normal; he also did not have a fever, chills, or abdominal guarding. An x-ray was taken in the late afternoon. Shortly thereafter, when Brown's abdomen became distended and firm, Dr. Osmundson ordered that he be transferred to the emergency room. The staff there diagnosed him with appendicitis and a perforated appendix. Brown was then rushed into emergency laparotomy surgery, which was successful.

Brown brought suit under 42 U.S.C. § 1983 against Dr. Osmundson, Nurse Edwards, and N.P. Miller,[2] alleging violations of his Eighth Amendment rights. He argued that had the prison staff caught his appendicitis before his appendix ruptured, it could have been treated with a simpler laparoscopy, which requires only minor incisions, instead of a laparotomy, which necessitates cutting open the abdomen to access the appendix. The defendants moved for summary judgment. In deposition testimony, Dr. Bernard, an emergency-room physician at Graham Hospital, opined that Brown's symptoms were general and not specific to any abdominal issue. He explained, without contradiction, that appendicitis can be difficult to diagnose. The "classic case" of appendicitis—distended abdomen, fever, nausea, vomiting, and an elevated white blood cell count—occurs infrequently. The district

[2] Brown also sued Wexford Health Sources, Inc. The district court dismissed the claim with prejudice, and Brown has not appealed that dismissal.

court granted summary judgment for the defendants. This timely appeal follows.

II. Discussion

Brown contends that the defendants violated the Eighth Amendment's Cruel and Unusual Punishment Clause by depriving him of necessary medical care. *See* U.S. Const. amend. VIII. We review a grant of summary judgment de novo, drawing all reasonable inferences in favor of the nonmovant. *Driveline Sys., LLC v. Arctic Cat, Inc.*, 936 F.3d 576, 579 (7th Cir. 2019). "Summary judgment is appropriate when there is no genuine dispute of material fact, and the moving party is entitled to judgment as a matter of law." *United States ex rel. Proctor v. Safeway, Inc.*, 30 F.4th 649, 658 (7th Cir. 2022). A genuine issue of material fact exists only if "there is sufficient evidence favoring the nonmoving party for a jury to return a verdict for that party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986).

"The Constitution 'does not mandate comfortable prisons,' but neither does it permit inhumane ones …." *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (quoting *Rhodes v. Chapman*, 452 U.S. 337, 349 (1981)); *see also Petties v. Carter*, 836 F.3d 722, 727 (7th Cir. 2016) (en banc). Because depriving a prisoner of medical care serves no valid penological purpose, "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)). To succeed on a deprivation-of-medical-care claim, a plaintiff must show that "(1) he had an objectively serious medical need (2) to which [the defendants] were deliberately indifferent." *Dean v. Wexford Health Sources, Inc.*, 18 F.4th 214, 241 (7th

Cir. 2021). Brown can easily satisfy the first inquiry. Appendicitis is an "objectively serious medical condition" that, left untreated, leads to a perforated (or ruptured) appendix, requiring invasive surgery to avoid serious injury and death. Brown has not, however, presented sufficient evidence to permit a trier of fact to find that the defendants were "deliberately indifferent" toward his medical needs.

Deliberate indifference requires a look into the subjective state of the defendants' mind. *Wilson v. Adams*, 901 F.3d 816, 820 (7th Cir. 2018) (quoting *Petties*, 836 F.3d at 728). A prison official acts with deliberate indifference only when he "*actually* [knows] of and disregard[s] a substantial risk of harm." *Dean*, 18 F.4th at 241 (quoting *Petties*, 836 F.3d at 728). "This is a high bar 'because it requires a showing [of] something approaching a total unconcern for the prisoner's welfare in the face of serious risks.'" *Rasho v. Jeffreys*, 22 F.4th 703, 710 (7th Cir. 2022) (quoting *Rosario v. Brawn*, 670 F.3d 816, 821 (7th Cir. 2012)). "[M]ere negligence" or even civil "objective recklessness" simply "is not enough." *Petties*, 836 F.3d at 728; *see also Farmer*, 511 U.S. at 836–38. An "official's failure to alleviate a significant risk that he should have perceived but did not … cannot … be condemned as the infliction of punishment." *Farmer*, 511 U.S. at 838. Moreover, medical malpractice "does not become a constitutional violation merely because the victim is a prisoner." *Estelle*, 429 U.S. at 106; *see also McGee v. Adams*, 721 F.3d 474, 481 (7th Cir. 2013) ("Deliberate indifference is not medical malpractice.").

A plaintiff must provide evidence, either direct or circumstantial, to prove deliberate indifference. *Petties*, 836 F.3d at 728. Direct evidence, we have observed, is rarely forthcoming. *Id.* Prison officials do not typically proclaim that they violated

the Constitution by ignoring a known risk. Instead, "[m]ost cases turn on circumstantial evidence." *Id.* Several circumstances can permit a jury to reasonably infer deliberate indifference, such as denial of medical treatment altogether, *Id.* at 729, delay of medical care, *Dobbey v. Mitchell-Lawshea*, 806 F.3d 938, 940 (7th Cir. 2015), continued ineffective treatment, *Conley v. Birch*, 796 F.3d 742, 747 (7th Cir. 2015), "a substantial departure from accepted professional judgment, practice, or standards," *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261–62 (7th Cir. 1996), ignoring an obvious risk, *Norfleet v. Webster*, 439 F.3d 392, 396 (7th Cir. 2006), and refusing care because of cost, *Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir. 1999).

Brown has no direct evidence that any of the defendants were deliberately indifferent to his appendicitis. Instead, he relies on circumstantial evidence, arguing that a reasonable jury could find that the medical team inexcusably delayed treatment, continued in a course of ineffective treatment, and grossly violated the standard of care.

The claim against Dr. Osmundson ultimately falls short of the demanding standard for deliberate indifference. *See Farmer*, 511 U.S. at 838. "[D]elays are common in the prison setting with limited resources …." *Petties*, 836 F.3d at 730. It is uncontested that appendicitis is difficult to diagnose; its symptoms mirror those of other abdominal ailments. Nurse Edwards first informed Dr. Osmundson of Brown's condition on February 25, several days after he developed symptoms. Dr. Osmundson provided some care by prescribing pain killers and ordering Brown be placed on 23-hour observation. The next morning, a non-defendant nurse told Dr. Osmundson that Brown was still in "discomfort," and Dr. Osmundson promptly admitted Brown into the infirmary. After the pain

worsened in the night, Dr. Osmundson saw the patient the next morning and detected positive bowel signs. He ordered imaging, vital checks, painkillers, a blood count, a metabolic panel, and a urinalysis. Several nurses observed Brown in pain over the next day, but it was not until very early in the morning that one of them relayed the information to Dr. Osmundson, who examined Brown six hours later. Even then, Brown's blood and urine tests were essentially normal, and Brown did not have a fever, chills, or abdominal guarding—the classic symptoms of appendicitis. Finally, once Brown's abdomen became distended, Dr. Osmundson immediately sent him to the hospital only three-and-a-half days after he learned of and began treating Brown's symptoms. Even an emergency-room physician there noted that Brown's symptoms were general and not particularly specific. While Dr. Osmundson could have been more attentive, he did provide care after only minimal, not inexcusable or excessive, delay. *Contra Miller v. Campanella*, 794 F.3d 878, 880 (7th Cir. 2015) (a two-month delay for a prisoner suffering from gastro-esophageal reflux disease); *Arnett v. Webster*, 658 F.3d 742, 752 (7th Cir. 2011) (a ten-month delay for a prisoner suffering from rheumatoid arthritis).

Additionally, Brown has not presented evidence that Dr. Osmundson knowingly persisted in a course of ineffective treatment. *See Greeno v. Daley*, 414 F.3d 645, 655 (7th Cir. 2005). Throughout the three-and-a-half days, Dr. Osmundson gradually changed his treatment in response to Brown's worsening symptoms. At first, he put Brown on painkillers and observation. When the situation did not improve, he admitted him into the infirmary for more monitoring, and the next day, he ordered imaging, vital checks, and a urinalysis. Brown's condition still declined, so Dr. Osmundson examined him,

waited for an x-ray, and sent him to the hospital as soon as a nurse reported Brown's abdomen became distended. His responses to Brown's health, even if negligent, do not amount to persisting "in a course of treatment known to be ineffective." *Petties*, 836 F.3d at 730.

Nor did Dr. Osmundson administer care that was "such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment." *Cole*, 94 F.3d at 261–62; *see also Petties*, 836 F.3d at 729 ("E]vidence that *some* medical professionals would have chosen a different course of treatment is insufficient to make out a constitutional claim."); *Norfleet*, 439 F.3d at 396 ("[T]he decision must be so far afield of accepted professional standards as to raise the inference that it was not actually based on a medical judgment."); *Steele v. Choi*, 82 F.3d 175, 179 (7th Cir. 1996) ("[T]he Supreme Court's holding in *Estelle* that the Eighth Amendment does not constitutionalize medical malpractice implies that there will be cases in which treatment falls below acceptable standards that do not state a claim for constitutional purposes."). Brown has furnished no evidence for his "substantial departure" assertion in the form of an expert opinion or otherwise. Dr. Osmundson treated Brown by gradually increasing monitoring and testing as his conditions worsened, and when necessary, he sent Brown to the hospital. At no point did Dr. Osmundson abandon his duties as a physician such that "no minimally competent professional would have so responded." *Collignon v. Milwaukee County*, 163 F.3d 982, 989 (7th Cir. 1998).

Brown relies on *Conley v. Birch*, 796 F.3d 742, and *Sherrod v. Lingle*, 223 F.3d 605 (7th Cir. 2000), to little avail. In *Conley*,

the prisoner broke his hand in a physical altercation with another inmate. 796 F.3d at 744. On Christmas Eve, he went to the healthcare unit for his pain, and the nurse believed there may have been a fracture. *Id.* She called the physician assigned to the facility, and upon consultation, the nurse prescribed an ice pack and some ibuprofen. *Id.* at 745. The doctor returned to work from the holidays five days later and examined the patient. *Id.* She then ordered an x-ray, which ultimately revealed a fracture. *Id.* Conley sued over the delays in providing medical care. *Id.* In determining that summary judgment was not appropriate, we emphasized the nurse's note of a "possible/probable fracture" indicated that she might have relayed the information to the doctor, who could have ignored the serious medical condition. *Id.* at 747. Thus, a reasonably jury could have found, based on the phone conversation, that the doctor "strongly suspected that [the plaintiff's] hand was fractured." *Id.* Brown, though, lacks any evidence that Dr. Osmundson ever knew of and disregarded a substantial risk of appendicitis. No notes appear in Brown's medical records, and no one testified to such a known risk.

Sherrod is similarly distinguishable. *See* 223 F.3d 605. The prisoner there also suffered from appendicitis. *Id.* at 608. He requested assistance, first on March 9, 1995, but was never admitted for observation. *Id.* He returned two days later, and a nurse wrote "rule out appendicitis." Again though, the prisoner was sent back to his cell despite complaints of abdominal pain and a lack of bowel activity. *Id.* On March 17, the doctor transferred him to the emergency room—at least eight days after his first symptoms. *Id.* at 609. The emergency-room doctor prescribed pain medication and a shot of a medication with orders to return for more testing, but the prison hospital staff at first refused to allow the prisoner to return for more

tests even as a nurse again noted "rule out appendicitis." *Id.* Eventually, the prisoner was treated for a ruptured appendix on March 24, over two weeks after he first informed the prison's medical staff of his symptoms. *Id.* Like in *Conley*, summary judgment was inappropriate because the prisoner's symptoms worsened over two weeks, a nurse noted possible appendicitis, and prison officials gave only slight care—an aspirin and an enema—before sending him back to his cell. *Id.* at 610–12. Brown's facts, however, are quite different: the defendants in *Sherrod* delayed care for significantly longer than Dr. Osmundson (fourteen days compared to the three-and-a-half days here), and evidence indicated that they knew of the risk of appendicitis. *Id.* at 611–12; s*ee also Conley*, 796 F.3d at 744.

Brown may have received subpar care in the prison's infirmary. Dr. Osmundson waited two days after Brown was wheeled into the prison's medical wing to examine the patient in-person. After Brown vomited through the entire night, and a nurse described his abdomen as "hard" at one point, a symptom of appendicitis, Dr. Osmundson refrained from sending him to the hospital immediately, instead opting to continue the pain treatment and take x-rays six hours later. In the words of one physician, Dr. Osmundson's decisions "led to … worsening of the patient's outcome and a more complicated and dangerous surgical procedure with increased length of time for recovery and hospitalization." Nothing in this opinion seeks to minimize Brown's suffering. But medical malpractice is not a constitutional violation. *McGee*, 721 F.3d at 481. Brown has not provided sufficient evidence, whether direct or circumstantial, to prove that Dr. Osmundson "actually knew of and disregarded a substantial risk of harm." *Dean*, 18 F.4th at 241 (quoting *Petties*, 836 F.3d at 728).

Turning to the nurses, we have little trouble concluding that N.P. Miller and Nurse Edwards did not act with deliberate indifference toward Brown's serious medical needs. N.P. Miller only saw Brown once, on February 23, 2017, for an originally unrelated appointment. There, Brown discussed his recent symptoms, but given the fact that he suffered from a hernia before, N.P. Miller could reasonably think that diagnosis caused this pain as well. She also acted promptly, prescribing medication to alleviate his pain. Brown argues that a jury could infer deliberate indifference from her refusal to see Brown when she returned from her vacation on February 27. That contention reads too much into an alleged (overheard) conversation by Brown. N.P. Miller managed a large staff of nurses who regularly checked on Brown at the same time Dr. Osmundson was treating him as well. A lone decision to not to reevaluate Brown when others, including a physician, were attending to him does not rise to deliberate indifference.

Nurse Edwards, too, diligently cared for Brown. She wrote down his symptoms, checked his vitals, relayed necessary information to Dr. Osmundson, and performed her assigned duties. The advanced treatment required to manage appendicitis cannot be given, in most cases, by a nurse. Only Dr. Osmundson could make the important decisions on whether and how to treat Brown's symptoms. Nurse Edwards could not override his judgment. Thus, she did not act with deliberate indifference either.

III. Conclusion

For these reasons, we affirm the judgment of the district court.

JACKSON-AKIWUMI, *Circuit Judge*, concurring. I agree with the majority that Dana Brown cannot meet the exceptionally high standard of deliberate indifference and therefore summary judgment in favor of all three defendants was appropriate. I write separately on two points.

First, the majority opinion describes Dr. Osmundson's six-hour delay before examining Brown on February 28 as "minimal" and "not … excessive," and contrasts that delay with the months-long delay at issue in *Miller v. Campanella*, 794 F.3d 878 (7th Cir. 2015) (two months) and *Arnett v. Webster*, 658 F.3d 742 (7th Cir. 2011) (ten months). But "the length of delay that is tolerable depends on the seriousness of the condition and the ease of providing treatment." *Smith v. Knox Cnty. Jail*, 666 F.3d 1037, 1040 (7th Cir. 2012) (citation omitted); *see also Gillis v. Litscher*, 468 F.3d 488, 492 (7th Cir. 2006) (citations omitted) ("Determining whether [a prisoner's] constitutional rights have been violated [under the Eighth Amendment] requires a 'fact-intensive inquiry under constitutional standards.'"). The cases the majority opinion highlights, *Miller* and *Arnett*, involved chronic conditions—gastro-esophageal reflux and rheumatoid arthritis, respectively. Brown's case involves an acute condition—appendicitis, which the record reflects can worsen to near fatal levels in a matter of days.

In our cases involving acute conditions or emergency medical situations, we have held that a delay of mere days or even hours can qualify as deliberate indifference. One such example is the two-week delay in our other appendicitis case, *Sherrod v. Lingle*, 223 F.3d 605, 611–12 (7th Cir. 2000). *See also Smith*, 666 F.3d at 1040 (citations omitted) ("Even a few days' delay in addressing a severely painful but readily treatable

condition suffices to state a claim of deliberate indifference."); *Lewis v. McLean*, 864 F.3d 556, 563–64 (7th Cir. 2017) (hour and a half was excessive delay when muscle spasms and back pain rendered prisoner immobilized); *Williams v. Liefer*, 491 F.3d 710, 716 (7th Cir. 2007) (citation omitted) ("[A] reasonable jury could have concluded from the medical records that the [six-hour] delay unnecessarily prolonged and exacerbated Williams' pain and unnecessarily prolonged his high blood pressure."); *Perez v. Fenoglio*, 792 F.3d 768, 778 (7th Cir. 2015) (collecting cases involving two-day delays).

In short, Brown's appendicitis was an emergent issue that required defendants to act quickly, and a six-hour delay *could* run afoul of the Constitution depending on when the defendants ascertained the seriousness of the condition. Brown's claim fails not because a six-hour delay is considered minimal under our caselaw, but because he does not supply sufficient evidence that Dr. Osmundson's delay, no matter the length, was the result of deliberate indifference.

Second, Brown argues in his appellate brief that Nurse Edwards was deliberately indifferent because she failed to call Dr. Osmundson when Brown's condition did not improve, especially during the critical early hours of February 28. Brown's argument fails because it is undisputed that Nurse Edwards did call Dr. Osmundson at least once after examining Brown during this time, which in any event, was after another nurse took over Brown's care.

The majority opinion states that Nurse Edwards could not provide the "advanced treatment required to manage appendicitis," as that was in Dr. Osmundson's purview, and she "could not override [Dr. Osmundson's] judgment," "[t]hus, she did not act with deliberate indifference." But to be clear, a

nurse is not immune from claims of deliberate indifference simply because there is a supervising doctor with decision-making power. "While nurses may generally defer to instructions given by physicians, they have an independent duty to ensure that inmates receive constitutionally adequate care," *Perez*, 792 F.3d at 779 (citation omitted), and a nurse confronting obvious indifference cannot turn a blind eye. *Reck v. Wexford Health Sources, Inc.*, 27 F.4th 473, 485–86 (7th Cir. 2022) (citations omitted) ("As a general matter, a nurse can, and indeed must, defer to a treating physician's instructions. However, that deference cannot be 'blind or unthinking.' Under some circumstances when a nurse is aware of an inmate's pain and the ineffectiveness of the medications, a delay in advising the attending physician or in initiating treatment may support a claim of deliberate indifference. 'Nurses, like physicians, may thus be held liable for deliberate indifference where they knowingly disregard a risk to an inmate's health.'"); *Lewis*, 864 F.3d at 564–65; *Holloway v. Del. Cnty. Sheriff*, 700 F.3d 1063, 1075 (7th Cir. 2012) (citation omitted); *Berry v. Peterman*, 604 F.3d 435, 443 (7th Cir. 2010) (citations omitted); *cf. McCann v. Ogle Cnty.*, 909 F.3d 881, 887 (7th Cir. 2018) (citation omitted) (nurse was not deliberately indifferent by relying on doctor's determination of proper dosage of methadone, "especially when nothing about [doctor's] prescriptions or course of care more generally raised any obvious risks of harm for McCann").

I do not understand the majority opinion to be inconsistent with this rule about nurses. With that understanding, I join the opinion.