Van Patten v. Pearce

United States District Court for the District of Oregon
May 29, 1991, Decided ; May 29, 1991, Filed
CV No. 87-298-PA

Reporter: 1991 U.S. Dist. LEXIS 21134

GUY VAN PATTEN, ADRIAN PLASENCIA, CHRISTOPHER KNAPP, JEROME WICKS, REX ALBERT LABO, Plaintiff, v. FRED PEARCE, Director, Oregon Corrections Division; R.L. WRIGHT, EOCI Superintendent; LINDA BRONSON, EOCI Health Services Manager, Defendants.

Counsel: [*1] For Plaintiffs: W. EUGENE HALLMAN, Mautz, Hallman, Pendleton, OR. STEVEN GOLDBERG, Goldberg & Mechanic, Portland, OR. ROY S. HABER, Attorneys at Law, Eugene, OR.

For Defendants: DAVE FROHNMAYER, Attorney General, JOHN R. McCULLOCH, JR., Chief Trial Counsel, Department of Justice, Salem, OR.

Judges: PANNER

Opinion by: OWEN M. PANNER

Opinion

OPINION

PANNER, J.

Plaintiffs Guy Van Patten, Adrian Plasencia, Christopher Knapp, Jerome Wicks, Rex Albert Labo, and other inmates at the Eastern Oregon Correctional Institution (EOCI) bring this civil rights class action under *42 U.S.C. § 1983* against defendants Fred Pearce, Director of the Oregon Corrections Division; R.L. Wright, EOCI Superintendent; and Linda Bronson, EOCI Health Services Manager. Plaintiffs claim that defendants violated their *eighth* and fourteenth amendment rights by providing constitutionally inadequate health care.

I held a court trial in Pendleton and heard final arguments in Portland. I find for plaintiffs and award interim attorney's fees. I deny defendants' motion for involuntary dismissal. These are my findings of fact and conclusions of law. Fed. R. Civ. P. 52(a).

FINDINGS OF FACT

Plaintiffs challenge [*2] the adequacy of health care at EOCI between June 1985 and March 1990. The parties agree that defendants have improved health care at EOCI since March 1990, but at this stage of the litigation I will not consider those improvements.

EOCI began with promise in 1985. Experienced, knowledgeable Department of Corrections officials planned EOCI's health care system. However, as EOCI expanded, its once adequate health care system was overwhelmed by the sheer number of inmates.

I. Inadequate Physician Staffing

A. Background

EOCI's first staff physician worked 10 hours per week, serving 275 inmates. In September 1986, EOCI contracted with Dr. Joseph Diehl to be Chief Medical Officer for only 5 hours per week, even though EOCI's inmate population was growing rapidly. In February 1988, Dr. Diehl began working 10 hours a week, but EOCI had 580 inmates. By January 1990, EOCI had more than 1,300 inmates. Between December 1986 and December 1989, EOCI's physician-to-inmate ratio varied from one full-time equivalent physician per 2,045 inmates in June 1987 to one full-time equivalent physician per 3,662 inmates in January 1988.

Dr. Diehl, health services manager Linda Bronson, and the EOCI nursing [*3] staff worked very hard and conscientiously. However, EOCI's small staff, even with the help of consulting physicians, simply could not care adequately for EOCI's hundreds of inmates.

B. Evidence of Understaffing

1. Budget Proposals

The Department knew that EOCI was understaffed, and it tried to convince the Oregon Legislature that EOCI and other state prisons needed to hire more physicians and nurses. Catherine Knox, Director of Health Services for the Department, recommended funding for two full-time physicians at EOCI for 1991-93 so that health care would be constitutionally acceptable. Exh. 10 at 10096; Exh. 130. Knox warned that if the Oregon Legislature did not adopt the Department's budget recommendations, "the following costs or impacts can be expected: an increase in the number of clinical episodes that are inadequately treated compromising the health, safety and life of inmates." Exh. 10 at 100694. Knox was aware that physician understaffing could violate the *eighth amendment*, noting that the Department would face increased costs from litigation and compliance with court orders.

2. The Norman Report

In 1989, the Department of Corrections hired prison health care [*4] expert Bonnie Norman to investigate the state's prisons and recommend improvements. The resulting "Norman Report," written with other consultants, found that the "obvious deficit in personnel resources [statewide] would support the conclusion that many functions relative to quality of care are unable to be met." Exh. 8 at 17. At trial, Norman testified that the report's criticisms did not necessarily apply to EOCI. She praised EOCI as "probably the better system in the department." 2 Tr. at 224.

However, Norman did not visit EOCI before the report was written. Kenneth Peterson, a consultant for Norman who did visit and evaluate EOCI, testified that EOCI was understaffed, allowing health care to be directed by nurses instead physicians. I accept Peterson's testimony, which was based on his own investigation. I reject Norman's testimony to the extent that it contradicts Peterson's testimony.

3. Testimony

Plaintiffs' expert, Dr. Charles Rosenberg, testified that EOCI's physician staffing was inadequate, especially because EOCI did not employ any nurse practitioners or physician assistants. I accept Dr. Rosenberg's opinion. Defendants' expert, Dr. Jay Harness, conceded that employing [*5] one full-time-equivalent physician for 2,600 inmates "could potentially be a problem." 3 Transcript (Tr.) 178. Peterson testified that a common rule of thumb is one full-time-equivalent physician per 1,000 inmates. He stated that a prison with EOCI's staff serving more than 1,300 inmates would be a "red flag." Peterson Depo. at 92. No expert testified that EOCI's physician staffing was adequate.

Defendants point to the testimony of four consulting physicians who worked a few hours per month at EOCI. They testified that inmates were treated promptly and appropriately. However, as defendants acknowledge, these physicians were "only marginally involved in the EOCI medical system." Corrected Closing Argument at 2.

Two inmates testified that they received good medical care while at EOCI. One of the inmates was in EOCI during its early days when physician staffing was much higher. The other inmate may have received adequate health care, but that does not support any general conclusions.

Defendants also argue that EOCI's inmates are less likely to need health care because they average 26 years old, five years younger than inmates statewide. However, defendants offered no evidence that younger [*6] inmates are particularly healthy. They may actually need more medical attention because of drug or alcohol abuse.

4. Published Guidelines

Dr. Rosenberg's expert opinion on physician staffing at EOCI is supported by guidelines from the National Commission on Correctional Health Care (NCCHC) and the American Public Health Association (APHA). Exh. 1 (APHA); Exh. 2 (NCCHC). The NCCHC recommends one full-time equivalent physician for 750 to 1,000 inmates, while the APHA recommends one full-time equivalent primary care physician for every 200 to 750 inmates. These guidelines are intended to be the bare minimum for adequate health care. Although I do not "constitutionalize" these guidelines, they are further evidence that EOCI's physician staffing was inadequate. *Cf.* *Hoptowit v. Ray,* 682 F.2d 1237, 1253 (9th Cir. 1982) (warning against constitutionalizing standards).

II. Use of Nurses

Physician understaffing forced EOCI to rely on nurses to manage health care. Because EOCI's nurses were not trained to operate without a physician's supervision, physician understaffing and reliance on nurses caused unnecessary pain and suffering.

A. Inadequate Education [*7] and Training

Almost all EOCI's nurses are registered nurses with two-year degrees or licensed practical nurses (LPNs) with one year of training. Two-year registered nurses and LPNs can determine normal and abnormal physical findings, perform technical tasks, and manage common diseases. However, they are not trained to diagnose and manage patients without a physician's supervision.

Because the nurses' education did not prepare them to work without a physician supervising them, EOCI should have ensured that they were given additional training. However, EOCI had no formal continuing education program for nurses and no peer review system.

Defendants contend that EOCI's on-the-job training was adequate. Dr. Diehl testified that "continuing education for health care professionals can be a continuous, daily process. In that sense, I have always been involved in the training of EOCI nurses." Supplemental Direct Testimony at 11. Dr. Diehl's continuing education classes for nurses consisted of brief conversations while he was busy treating inmates and signing orders. That is no substitute for formal training.

Inadequate training resulted in needless pain and suffering. One nurse tried to reset [*8] what she had diagnosed as a

dislocated shoulder, although the inmate actually had a torn muscle. Another nurse diagnosed an inmate with a history of epididymitis as suffering from "possible lover's nuts" and encouraged masturbation. Another nurse chose to evaluate an inmate for thirty minutes rather than rushing the inmate to the local hospital when the inmate was found suffering from severe chest pain, heavy sweating, and an irregular pulse. EOCI's nurses also made many correct assessments, but that does not justify the risk allowing them to operate beyond the scope of their training.

B. Failure to Supervise Nurses

Because of his limited hours, Dr. Diehl did not have time to supervise nurses properly. Nurses, including LPNs, conducted sick call without Dr. Diehl, and he did not review daily logs of sick call or all progress notes. He reviewed chart notes if they were brought to his attention, and he signed charts when a nurse implemented a written standing order.

The lack of supervision meant that nurses, not Dr. Diehl, managed inmate health care. Nurses decided whether an inmate's condition was serious enough to warrant an examination by Dr. Diehl. Inmates with chronic problems [*9] received treatment only during flare-ups or acute episodes. During emergencies, nurses were sometimes forced to make crucial decisions themselves because they could not reach Dr. Diehl by telephone.

Defendants cite two examples of Dr. Diehl acting as a "clinical supervisor" correcting nurses' mistakes. Corrected Closing Argument at 22. However, plaintiffs do not contend that Dr. Diehl *never* supervised nurses, only that his supervision was inadequate.

C. The Use of Standing Orders

When nurses evaluated and treated inmates, they were to be guided by written "standing orders" issued by Dr. Diehl. Standing orders instructed nurses on treating a particular illness or injury. However, standing orders assume that the nurse is trained to assess an inmate's condition. EOCI had no training in carrying out standing orders. When the nurse is not adequately trained, the standing order becomes useless or even dangerous. Nurses were left to diagnose, treat, and sometimes offer prescription medication without any physician involvement. In some cases, the nurse did not have even a standing order for guidance.

Dr. Rosenberg testified that EOCI should replace standing orders with treatment protocols, [*10] which are written orders specifying the procedure to follow when assessing an inmate's condition. Treatment protocols differ from standing orders because they authorize the nurse to treat
the inmate only after receiving a physician's written or oral direction. Treatment protocols do not include dispensing prescription drugs. Both Dr. Harness and Norman testified that prisons nationally are abolishing standing orders and adopting treatment protocols, and Norman recommended replacing standing orders with treatment protocols.

Dr. Diehl defended standing orders, testifying that there was little difference between a standing order and "a doctor's verbal direction to initiate medication before he has a chance to see the patient." Supplemental Direct Testimony at 13. However, because standing orders require that the nurse assess an inmate's condition without consulting the physician, the physician would not review the nurse's decision for hours or even days. Treatment protocols are intended to insure that the physician is included in the initial diagnosis and treatment.

III. Mental Health Care

A. Inadequate Mental Health Staffing

EOCI contracted with Charles Manley, a mental health specialist, [*11] and several consulting psychiatrists to treat mentally ill inmates. As of 1988, Manley was working about twenty hours per week. Consulting psychiatrist Dr. Charles Johnston averaged about eight hours a month.

Defendants knew that Manley and Dr. Johnston could not adequately care for EOCI's mentally ill inmates. Dave Hickerson, EOCI's program manager, described EOCI's problems candidly in a draft budget report. Hickerson stated that EOCI had an inadequate mental health staff, did not screen newly admitted inmates for mental illness, did not monitor mentally ill inmates, and could not handle inmates with major psychiatric disorders. Hundreds of less seriously ill inmates were on waiting lists for mental health treatment. Hickerson concluded that without adequate staffing, EOCI would continue "revolving door" mental health treatment, releasing mentally ill inmates who still suffered from the treatable mental illness that caused their admission.

Defendants dispute the value of Hickerson's report, noting that he is not a mental health expert. However, I find Hickerson's report is factual and credible. His statements are supported by other evidence, including the Norman Report, Peterson's [*12] testimony, and Dr. Rundle's testimony.

Defendants contend that fewer than 1% of inmates at EOCI are seriously mentally ill. I find that this reflects a narrow definition of mental illness. The Department's own employees and consultants have estimated that between

10% to 15% of EOCI's inmates are mentally ill. Two consultants, Drs. J.H. Treleaven and Eric Trupin, estimated that 10% of inmates statewide have a significant psychiatric disability. EOCI assistant superintendent George Baldwin estimated that 10% to 15% of EOCI's inmates were mentally ill. Peterson Depo. at 39. I find that 10% is a better estimate of the incidence of mental illness at EOCI.

Dr. Treleaven also estimated that 15% to 20% of inmates would need mental health services, and 5% would need acute psychiatric services. In addition, up to 10% would be at risk of situational crises that were unmanageable in the general population and not appropriate for housing in segregation. EOCI's mental health staff is too small to care adequately for its mentally ill inmates.

Defendants do not dispute plaintiffs' figures on mental health staffing at EOCI. Rather, they contend that Dr. Diehl and EOCI's nurses are qualified to conduct [*13] mental health evaluations. Assuming that is true, mentally ill inmates must also be treated. There is no evidence that Dr. Diehl or EOCI's nurses treated mentally ill inmates.

B. Evaluation and Treatment

Counseling sessions with Manley or a psychiatrist were brief and infrequent for most inmates. Manley usually counseled inmates no more than 20 minutes, while the contract psychiatrist spent no more than 10 minutes with each inmate. When inmates asked to see a psychiatrist, they were often referred to "Dr." Manley, though Manley held only a master's degree.

Mentally ill inmates were often housed in segregation for weeks or months without treatment. In one case, an inmate with a history of psychiatric hospitalizations and suicide attempts was seen by a physician on September 13, 1986. The physician placed the inmate on psychotropic medication and recommended a psychiatric evaluation. However, Dr. Johnston did not evaluate the inmate until February 6, 1987, diagnosing chronic schizophrenia.

Defendants are very concerned about distinguishing between "bad" and "mad" inmates, that is, between inmates who manipulate the system and those who truly suffer from mental illness. However, as defendants [*14] acknowledge, the line is difficult, if not impossible, to draw. Inmate Vincent Jones is a case in point. Jones was admitted to EOCI with a long history of suicidal gestures and self-mutilations.

Dr. Diehl testified that "it is the opinion of every examiner who has seen him that Jones does not have any mental illness." Supplemental Direct Testimony at 20. Dr. Diehl considered Jones's self-destructive behavior harmless. However, Dr. Diehl apparently ignored the evaluations of EOCI's own mental health experts. Both Dr. Johnston and Manley considered Jones seriously mentally ill. Dr. Johnston diagnosed a bipolar disorder, manic or cyclic, for which he prescribed lithium and psychotropic drugs. Manley did not consider Jones's self-mutilations harmless. Instead, he thought that they "could be life-threatening at some point."

Jones's treatment at EOCI shows that EOCI is not equipped to handle seriously mentally ill inmates. Jones has been on segregation continuously for months, often on "yard restriction," forbidden from exercising. He is frequently placed in restraints, sometimes full "cradle" restraints, and he continues to mutilate himself. During ten months of segregation, Manley saw [*15] Jones only nine times, and Johnston saw him six times. All the visits were brief.

C. Use of Segregation and Restraints

EOCI had no written policies or standing orders for psychiatric problems. It had no written suicide prevention plan.

EOCI punished suicidal gestures with disciplinary segregation. Defendants contend that inmates are not disciplined for suicidal gestures themselves, but for rule infractions. For example, an inmate would be disciplined for breaking a porcelain sink to obtain a sharp edge for self-mutilation.

The disciplinary records belie defendants' claim. Jones was disciplined on October 10, 1989 and on December 6, 1989 for refusing orders to stop reopening self-inflicted wounds. Exh. 47 at 15-16, 19-20. On February 16, 1990, a guard found Jones squirting blood from cuts on his left arm. Jones was disciplined for refusing to stop spraying blood. Another inmate, Monte Gillespie, was disciplined because he "wilfully self-inflected [sic] a wound to his left wrist and must be segregated to prevent him from persisting in this type of misconduct." Exh. 48 at 1.

EOCI had no written policy on restraints. EOCI staff used handcuffs, belly chains, and leg shackles to control [*16] psychotic or suicidal inmates in segregation.

Plaintiff's expert Dr. Rundle testified that restraints are psychologically harmful. Defendant's expert, Dr. Reid, testified that "there is no indication that restraint is bad for the person's mental illness or contributes to deterioration in any way." 3 Tr. at 15. However, Dr. Reid testified that restraints may cause acute symptoms, anxiety, and discomfort. *Id.* at 24. Even if Dr. Reid is correct that restraints do not exacerbate an inmate's underlying mental illness, I accept Dr. Rundle's testimony that restraints are

harmful and should be used only when absolutely necessary. Dr. Reid stated that except in emergencies, a physician should be involved in deciding whether to use restraints. Although segregation and restraints are obviously effective at controlling behavior, they are not a substitute for observation and treatment.

IV. Inadequate Medical Records

Good medical records are crucial to proper health care. However, EOCI's records were poorly recorded and maintained. The Norman Report found that EOCI staff kept progress notes for months without placing them on an inmate's chart, and often did not try to review a inmate's history [*17] when seeing him at sick call. Physician progress notes were missing or rare. Nurses did not state which, if any, standing order they had implemented when treating an inmate. Dr. Diehl rarely indicated in writing whether he had reviewed the nurse's treatment.

Medication records were messy and confusing, and contained no stop dates. Stop dates allow the physician to review a chronically ill inmate's treatment.

Inadequate medical records caused needless pain and suffering. When nurses or physicians attempt to assess an inmate's condition without a full medical history, the inmate may receive incorrect treatment or have a chronic problem ignored.

EOCI's inadequate records made plaintiffs' task at trial more difficult. Defendants seemed to have reversed the maxim cited by the Norman Report and plaintiffs' experts: "If you didn't document it, you didn't do it." Exh. 8 at 71. When defendants disputed Dr. Rosenberg's statement that a nurse rather than Dr. Diehl ordered an inmate's urology examination on December 15, 1986, Dr. Diehl simply added a "late entry" to the inmate's chart, dated April 16, 1990. This "late entry" indicates an unusually cavalier approach toward keeping records.

V. [*18] Prosthetic Devices

The Department requires that inmates pay for prosthetic devices such as eyeglasses, dentures, and artificial limbs if the prosthesis is not "medically necessary." Exh. 8, at 34. I agree with the Norman Report that this vague standard could prevent inmates from receiving necessary prosthetic devices.

Inmate Terry Joynt, whose left leg was amputated above his knee, was admitted to EOCI in fall 1987. In late December 1987, nurses noted that Joynt's stump was swollen, red, and painful because of his ill-fitting artificial leg. Joynt spent several weeks in the infirmary. Joynt left the infirmary but suffered back problems because of his crutches.

Dr. Diehl had tried to get Joynt to lose weight and reduce the stump rather than purchasing a new artificial leg. In May 1988, Dr. Diehl noted that artificial leg still would not fit on the stump. Joynt did not receive a new artificial leg until he saved enough money to purchase one in late 1989.

Joynt had no teeth or dentures. EOCI required him to purchase his own dentures, while feeding him pureed food. Joynt also requested eyeglasses because he had broken his old pair. After being told initially that he did not need eyeglasses, [*19] Joynt later verified that he did need them and purchased a pair.

VI. Emergency Transportation

EOCI sometimes used prison vehicles to transport inmates to the local hospital in emergencies. The prison vehicles did not contain medical supplies and were not staffed by medical personnel.

CONCLUSIONS OF LAW

The *eighth amendment*, which applies to the states through the fourteenth amendment, prohibits cruel and unusual punishment. The *eighth amendment* rests on the premise that the government should treat inmates as human beings. *LeMaire v. Maass,* 745 F. Supp. 623, 628 (D. Or. 1990). It proscribes not just brutal punishments, but also punishments that violate current standards of dignity, humanity, and decency. *McKinney v. Anderson,* 924 F.2d 1500, 1504 (9th Cir. 1991). Because inmates cannot care for themselves, the state has a constitutional duty to look after their health and well-being. *Id.*

However, the *eighth amendment* does not guarantee inmates the highest quality medical care. It prohibits only deliberate indifference to inmates' serious medical needs. *LeMaire,* 745 F. Supp. at 628.

In [*20] deciding whether prison medical care violates the eighth *amendment, I* am guided by current expert opinions. I must examine each challenged condition individually and objectively, but I must also consider the possibility that the conditions exacerbate one another in the prison. *Id.* at 629.

In a class action challenging prison medical care, inmates may prove *eighth amendment* violations by showing repeated examples of negligent medical treatment, or by showing a failure to remedy systemic deficiencies in health care services. *See DeGidio v. Pung,* 920 F.2d 525, 533 (8th Cir. 1990) (collecting decisions holding that "a consistent pattern of reckless or negligent conduct is sufficient to establish deliberate indifference to serious medical needs"); *Cleveland-Perdue v. Brutsche,* 881 F.2d 427, 431 (7th Cir. 1989) (courts had reached a "clear

consensus" by 1975 that "a prison official's failure to remedy systemic deficiencies . . . constituted deliberate indifference to an inmate's medical needs"), *cert. denied,498 U.S. 949, 111 S. Ct. 368, 112 L. Ed. 2d 331 (1990)*. [*21]

Here, plaintiffs have attempted to prove their claims through both methods. Because defendants' medical records are inadequate and the evidence is often unclear, I will not rely on a pattern of negligent conduct. Instead, I conclude that defendants were deliberately indifferent to plaintiffs' serious medical needs because they were aware of systemic deficiencies in health care at EOCI but failed to correct them. The Department's efforts to study and correct EOCI's shortcomings are commendable, but do not absolve it of the responsibility to provide adequate health care. *See Dean v. Coughlin,* 623 F. Supp. 392, 402 (S.D.N.Y. 1985). EOCI's inadequate physician staff, over-reliance on nurses, inadequate mental health care, incomplete medical records, and policy on prosthetic devices each violated plaintiffs' *eighth amendment* rights.

I. Physician Understaffing

I conclude that EOCI's physician staffing was too low to provide constitutionally adequate health care. Defendants were aware of the understaffing, showing deliberate indifference to inmates' serious medical needs.

Defendants do not dispute plaintiffs' physician-to-inmate figures. Instead, they accuse [*22] plaintiffs of playing a "numbers game" and argue that I should focus instead on the outcome of EOCI's health care system. I agree that actual results are the ultimate measure of health care. EOCI's health care system was not constitutionally acceptable.

Defendants' expert Dr. Jay Harness measured the quality of EOCI's outcome by counting inmate deaths and inmate grievances. Two inmates died at EOCI during the relevant time, and few inmates filed grievances about their medical treatment.

However, a low death rate does not necessarily show adequate health care. The *eighth amendment* requires that defendants do more than simply keep inmates alive. Defendants must also prevent unnecessary suffering. *LeMaire v. Maass,* 745 F. Supp. 623, 628 (D. Or. 1990). Nor does the lack of inmate grievances show that inmates were satisfied with their health care. After this case became a class action, inmates often notified plaintiffs' attorneys about health care problems rather than filing grievances with EOCI.

II. Use of Nurses

Defendants argue that EOCI's nurses acted properly because they were practicing within the scope of their licenses. However, the issue is whether [*23] EOCI's nurses were operating beyond their training, not whether they complied with state law. As the Norman Report stated, "even if licensure allows for this scope of [nursing] practice, it would require close supervision review. Supervision of non-physician providers is almost non-existent." Exh. 8 at 21.

EOCI's use of standing orders also caused unnecessary pain and suffering. Defendants contend that I am overruling *Capps v. Atiyeh,* 559 F. Supp. 894, 912 (D. Or. 1982), which stated that "while standing orders may not take the place of doctors, they do allow the nurses and medical technicians to assume the responsibility of a doctor in a limited way." I agree with *Capps* that standing orders are not per se improper. However, as the *Capps* court noted, standing orders cannot replace physicians. When nurses are not trained to implement standing orders, standing orders should not be used.

III. Mental Health Care

EOCI's mental health care system has caused needless pain and suffering, violating the *eighth amendment*. Defendants had far too few mental health staff to care for EOCI's mentally ill inmates. Mentally ill inmates languished in disciplinary [*24] segregation without adequate treatment. Psychotic or suicidal inmates were restrained for long periods unnecessarily.

Defendants' mental health expert Dr. Reid, like Dr. Harness, focused on outcome, noting that only one inmate at EOCI has committed suicide. However, EOCI's duty to treat mental illness does not end with preventing suicides. Imposing full restraints and segregation will prevent self-destructive behavior, but defendants also must avoid inflicting unnecessary suffering through the unsupervised overuse of restraints and segregation.

Staff members use steel cuffs and chains to control psychotic or suicidal inmates. Such restraints should be used only when a qualified mental health specialist recommends them, and then as briefly as possible.

IV. Medical Records

Defendants' failure to keep adequate medical records has delayed proper treatment and caused unnecessary pain and suffering, violating the *eighth amendment*. Well-kept medical records are crucial to an adequate health care system. When records are incomplete or unavailable, the physician or nurse cannot make a proper diagnosis.

V. Prosthetic Devices

Defendants' policy on prosthetic devices was deliberately indifferent [*25] to inmates' serious medical needs,

causing avoidable pain and suffering. Inmates must not be prevented from receiving medically necessary prosthetic devices because they cannot afford them.

VI. Emergency Transportation

Defendants' use of prison vehicles for emergency transportation was not deliberately indifferent to plaintiffs' serious medical needs. When a nurse or physician determined that an inmate needed emergency treatment at the local hospital, prison vehicles provided adequate transportation.

VII. Defendants' Motion to Dismiss

Defendants move to dismiss claims based on a pattern of deliberately indifferent medical care, contending that plaintiffs must use statistically reliable methods to prove such claims. I disagree. I have found no decisions requiring that plaintiffs establish *eighth amendment* violations statistically.

CONCLUSION

I find for plaintiffs. Defendants' motion for involuntary dismissal is denied. Plaintiffs may submit a petition for attorney's fees in twenty days.

DATED this 29th day of May, 1991.

OWEN M. PANNER, United States

District Court Judge

ORDER

PANNER, J.

I find for plaintiffs. Defendants' motion for involuntary dismissal is denied. Plaintiffs [*26] may submit a petition for attorney's fees in twenty days.

IT IS SO ORDERED.

DATED this 29th day of May, 1991.

OWEN M. PANNER, United States

District Court Judge