Matter of Upsher v State of New York
2014 NY Slip Op 33602(U)
January 31, 2014
Court of Claims
Docket Number: 115797
Judge: Christopher Jude McCarthy
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STATE OF NEW YORK COURT OF CLAIMS

In the Matter of the Claim of STEVEN UPSHER,

Claimant, DECISION

-v-

STATE OF NEW YORK, Claim No. 115797

Defendant.

BEFORE: **HON. CHRISTOPHER J. McCARTHY**
Judge of the Court of Claims

APPEARANCES:

For Claimant:
TOBEROFF, TESSLER & SCHOCHET, LLP
By: Brian Schochet, Esq.

For Defendant:
ERIC T. SCHNEIDERMAN
Attorney General of the State of New York
By: G. Lawrence Dillon, Esq., AAG

Claimant, Steven Upsher, established, by a preponderance of the credible evidence, his claim of medical malpractice against the State. The Court finds Defendant 100% liable because it failed to properly and promptly diagnose and treat Claimant's complaints of rectal bleeding while he was an inmate at Mid-State Correctional Facility located in Marcy, New York ("Mid-State"). The Court further finds that failure deprived Mr. Upsher of a substantial possibility of avoiding the development of Stage III colon cancer which necessitated surgery and subsequent chemotherapy. The Court awards damages of $1,200,000 for Mr. Upsher's past and future pain and suffering, as described below.

A unified trial, addressing both liability and damages issues, was held on January 8-11, 2013 and January 16-17, 2013 at the Court of Claims in Utica, New York. There were six witnesses: Claimant; Dr. Venkata R. Mannava (who treated Claimant for the State); Wayne Visalli, registered nurse ("RN") (who also treated Claimant for the State); Dr. Maxwell Chait (one of Claimant's experts); Dr. Gino C. Bottino (Claimant's other expert); and Dr. Thomas C. Mahl (Defendant's expert). In addition, testimony was read into the record from the separate August 20, 2009 depositions of Amy Ferguson, nurse practitioner ("NP") and Dr. Subbarao V. Ramineni, respectively, each of whom treated Claimant for the State. Thereafter, the parties requested and were granted additional time to review and submit an additional exhibit, and then to submit post-trial memoranda.

PHYSICIANS' CREDENTIALS

Each of the doctors who testified at trial is a New York-licensed physician. In addition to engaging in the private practice of family medicine, Dr. Mannava began working, part time, as a prison doctor at Mid-State in March, 2006. Dr. Mahl is board certified in internal medicine and gastroenterology, but not in oncology or hematology. He has worked at the Western New York Veterans' Hospital in Buffalo (the "Buffalo VA") for nearly 24 years, and also is a professor at the University of Buffalo Medical School.

Dr. Chait is board certified in internal medicine and gastroenterology. He has performed over 20,000 colonoscopies and endoscopies. He is an assistant clinical professor of medicine at Columbia University and is an editor at two peer-reviewed medical journals. Dr. Chait also maintains a private gastroenterological practice in Hartsdale, New York.

Dr. Bottino is board certified in internal medicine, hematology and oncology. He founded, and continues to work at, the cancer center of Northern Westchester Hospital. Dr. Bottino has maintained a private oncology practice for over 30 years. He has taught in the field of oncology at New York Medical College for the past 18 years. He does not perform colon cancer surgery, nor does he perform colonoscopies, although he has done sigmoidoscopies in the past.

In order to form the opinions they expressed at trial, Doctors Mahl, Chait and Bottino each reviewed Claimant's medical records from the Department of Corrections and Community Supervision ("DOCCS"[1]) and Bellevue Hospital, as well as certain deposition transcripts.

CLAIMANT'S CARE WHILE IN STATE CUSTODY

Claimant testified that he was born in 1963, has a third-grade education, and is illiterate. A chronology of Mr. Upsher's pertinent complaints and treatment while in State custody follows.

November 7, 2006

Dr. Mannava testified that Claimant did not have any health complaints at his physical examination on November 7, 2006, during which the doctor would have reviewed various bodily systems, including gastrointestinal ("GI") issues, and noted any complaints or problems (*see* Ex. 5, p. 6; Ex. 11[check box left blank indicating that no digital rectal exam was performed]). Dr. Ramineni confirmed that annual exams include an assessment of a patient's abdomen and GI tract and typically include a rectal examination.

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[1] Effective April, 2011, the Department of Correctional Services ("DOCS") and Division of Parole were merged to form the Department of Corrections and Community Supervision ("DOCCS").

January 4, 2007

Claimant testified that he first noticed blood in his stool at the beginning of January, 2007 and went to sick call the next day. His Ambulatory Health Record ("AHR") indicates that Mr. Upsher presented at sick call on January 4, 2007, complaining about hemorrhoids, jock itch and athlete's foot (Ex. 5, p. 7). Claimant said that he told the nurse about the blood in his stool. The AHR note records that Mr. Upsher did not have abdominal pain and did not report having passed any black stool. Claimant testified that the nurse told him he had hemorrhoids. He was prescribed a hemorrhoid cream and a cream for jock itch and athlete's foot (Ex. 5, p. 7).

Dr. Mannava and Dr. Ramineni each agreed that Claimant's complaints about jock itch and athlete's foot were not pertinent to the AHR entry concerning abdominal pain and black stool. Rather, Dr. Mannava and Dr. Chait each believed that information was obtained as a result of "targeted questions" the nurse asked, based upon the patient's subjective complaint of hemorrhoids, and indicate that Claimant had complained about rectal bleeding.

Dr. Mahl stated that "any presentation of unexplained, uninvestigated ... blood per rectum would interest me and concern me."[2] Dr. Mannava said, however, that the nurse determined that Claimant did not need to be evaluated by a doctor because no follow-up (often indicated in the medical records by the abbreviation, "F/U") was included in the AHR entry.

Dr. Mannava agreed that, in general, it is a departure from good practice for a nurse, either to fail to record in the AHR a patient's complaint of rectal bleeding, and/or to fail to refer such a patient for evaluation by a physician. As to the case at hand, Dr. Mahl said "this patient needed

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[2] All quotations not otherwise attributed are taken from the electronic recording of the trial and/or the Court's trial notes.

further evaluation," so that the failure by the nurse to refer him to a physician was departure from good and accepted practice. Dr. Chait agreed with Dr. Mahl's assessment, adding that the physician's evaluation should have included a colonoscopy. Dr. Chait further opined that it was a departure from good and accepted practice, in this instance, to tell Claimant he had hemorrhoids when he complained of blood in his stool because the rectal bleeding required further evaluation. In Dr. Bottino's opinion, the nurse's failure to refer Claimant to a physician on January 4, 2007, deprived Mr. Upsher of a substantial possibility of avoiding the development of colon cancer and the need for surgery and chemotherapy.

January 31, 2007

Claimant presented twice at emergency sick call (noted "ESC" in the AHR) on January 31, 2007, the first time at 12:30 p.m. and the second at 3:20 p.m. (Ex. 5, p. 9). The AHR indicates that Mr. Upsher complained that he had been experiencing rectal bleeding for a period of from two weeks (first note) to six weeks (second entry) (*id.*). Mr. Upsher testified that he had been bleeding for "over a month." At the noontime evaluation, Claimant was instructed to follow-up with sick call to request an appointment with a doctor (*id.*). When Claimant came back later that afternoon, however, he was admitted to Mid-State's infirmary for observation of his rectal bleeding condition (*id.*, pp. 9-10). The nurse recorded that Claimant had a bowel movement at 8:00 p.m. and that a "mod[erate] am[oun]t of frank blood mixed [with] stool" was observed (*id.*, p. 10). Dr. Mannava agreed that "frank blood" means blood that is red in appearance (i.e., it looks like blood).

February 1, 2007

By the next morning, Claimant had not experienced any further episode of "acute bleeding" (Ex. 5, p. 10). In his testimony, however, Dr. Mannava agreed that a confirmation of frank red blood

mixed with stool requires further testing in order to establish its cause, which can range all the way from a benign condition, such as hemorrhoids, to a serious illness, such as colon cancer. Dr. Chait called it "a significant finding." Dr. Mahl, likewise, stated that, while it was a favorable sign that the bleeding had abated, it "would not dissuade" him from keeping colon cancer on the differential diagnosis, and further testing was required.

In fact, NP Ferguson, who began working at Mid-State in October, 2005, did order several laboratory tests to identify the source of the bleeding. Among those tests were a complete blood count ("CBC") and "stool Guaiac x 3" test (Ex. 5, p. 11). Dr. Mannava agreed that the primary reason to order a CBC in a case of rectal bleeding is to determine the level of hemoglobin, the oxygen-carrying protein in blood. Anemia, or blood loss, would be reflected in a low hemoglobin level. Stool Guaiac, or fecal occult stool, tests analyze specimens to detect the presence of even microscopic levels of blood in the stool samples. Dr. Mannava and Dr. Ramineni each agreed that specimens are collected from three separate days because cancers can bleed intermittently and, therefore, a positive result for blood in any one sample is an indication that a potentially serious condition exists and that a colonoscopy is required. Dr. Mahl, likewise, said that colon cancers bleed intermittently, though he thought less so than do hemorrhoids.

NP Ferguson's direction, contained in the "health provider's order sheet" (*see* Ex. 5, p. 11), was that a follow-up visit be scheduled for Claimant to meet with her[3] on a date when his lab results were expected to be available (Ex. 5, p. 11). Claimant was discharged from the infirmary on the morning of February 1, 2007 by RN Visalli (*id.*, pp. 9-10). At that time, RN Visalli had been

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[3] Since she was the only "NP" at Mid-State, the notation "F/U [with] NP" had to refer to NP Ferguson (*see* Ex. 5, p. 11).

working at Mid-State for over seven years. It was his job to effectuate NP Ferguson's instructions, but the written discharge instructions he provided and explained to Mr. Upsher do not indicate in the space provided on the form that Claimant should expect a follow-up appointment to see medical staff again after the lab results came back (*see id.*, p. 12). At trial, RN Visalli agreed that the follow-up appointment box should have been checked, but it was not.

Dr. Chait opined that RN Visalli's failure to schedule the follow-up appointment pursuant to NP Ferguson's order was a departure from good and accepted practice. Likewise, the portion of the form instructing Claimant to report to sick call if he experienced certain enumerated complaints was left blank (Ex. 5, p. 12). Dr. Chait further opined that it was a departure from good and accepted practice not to tell Claimant to come back if he experienced further rectal bleeding.

It does appear that Claimant's CBC tests were ordered on February 1, 2007 and Mr. Upsher said that he went back the next day, on February 2, 2007, at which time his occult blood tests were ordered (*see* Ex. 5, pp. 13, 24; Ex. 6). Dr. Chait testified, however, that simply ordering CBC and stool Guaiac tests were "incomplete in this situation." Rather, he said that the standard of care for a patient presenting with Mr. Upsher's history of rectal bleeding and after having confirmation, by observation, of frank red blood mixed with stool, was to refer the patient to a gastroenterologist for a colonoscopy. Dr. Chait opined that NP Ferguson's failure to do so constituted a departure from that standard. Dr. Bottino agreed and said that failure deprived Claimant of a substantial chance of avoiding a Stage III cancer because, in his opinion, Claimant had, at most, a Stage I or Stage II cancer up until his discharge from State custody in June, 2007.

February 5, 2007

The lab report for Mr. Upsher's stool Guaiac test was received a few days later. All three of the occult stool samples were positive for fecal blood. Dr. Mahl testified that three positive Guaiac tests "should raise concern, ... that's not normal. You're not supposed to have blood in your stool ... Most providers faced with three Guaiac positive tests would interpret that as a sign that further testing needed to be done ... The community standard would ... mandate the performance of a colonoscopy. Or, at least a colonoscopy should be discussed with the patient. That's the standard of care." Dr. Mahl agreed that the failure to prescribe a colonoscopy after any positive fecal occult test would be a departure from good and accepted practice.

Dr. Chait, similarly, said that three positive Guaiac tests was a "very significant" and "dramatic demonstration of active rectal bleeding," which only served to confirm the visual observation of frank red blood, and "definitely" required that a colonoscopy be performed in accordance with a number of national treatment protocols.

Instead of requesting a colonoscopy, however, NP Ferguson signed the report at the bottom of the page, along with the note "F/U sched[uled]," (Ex. 6), apparently in the (mistaken) belief that an appointment already had been arranged in accordance with her earlier instruction.

February 6, 2007

Claimant appeared at sick call again on February 6, 2007, complaining of back pain and that he still was passing bloody stool (Ex. 5, p. 14). Dr. Mannava agreed that the visit was not a follow-up appointment prompted by the positive results of the stool Guaiac test. Dr. Chait, likewise, characterized the February 6, 2007 sick call visit as a matter of "happenstance." The AHR entry did

note that a follow-up appointment with a doctor was scheduled for February 13, 2007 (*id.*, p. 14). Dr. Chait observed, however, that the AHR note made no reference to the blood test results.

February 13, 2007

At trial, Dr. Mannava had little or no recollection of his examination of Mr. Upsher on February 13, 2007. His entry in Claimant's AHR indicates that Mr. Upsher presented with subjective complaints of rectal bleeding for the past four to six weeks associated with "heart burn" and that Mr. Upsher's abdomen was not tender (Ex. 5, p. 14). Dr. Mahl stated, however, that "heartburn is not an adequate explanation for the patient's symptoms," necessitating that other causes for the rectal bleeding be established.

Dr. Mannava's note also indicates, and at trial he confirmed, that, when he examined Mr. Upsher on February 13, 2007, he knew that all three of the stool Guaiac samples tested positive. He also had reviewed the CBC and other tests because he noted in the AHR that they were within normal limits ("WNL") (Ex. 5, p. 14). The entry does not indicate, and Dr. Mannava could not recall, however, whether he reviewed other pertinent prior AHR entries, infirmary notes, and older lab results.

The AHR entry also states that Mr. Upsher "adamantly refused" to permit Dr. Mannava to perform a digital rectal examination (Ex. 5, p. 14). At trial, Dr. Mannava conceded, however, that, even if Claimant had consented to an examination in February, 2007, it would have been negative. It would not have revealed the rectal mass identified in the December 17, 2007 Bellevue Hospital pathology report because the mass was located 18-25 centimeters ("cm") from the anus and, thus, beyond the reach of a digital examination (*see* Ex. 10). Rather, a colonoscopy or sigmoidoscopy would have been required in order to discover the rectal mass.

Moreover, Dr. Mannava agreed that the tumor found in December would not have been any closer to the anus when he examined Mr. Upsher in February. Consistent with that, he further agreed that Claimant appeared to have consented to rectal examinations when he presented at Bellevue's emergency room ("ER") on July 20, 2007 and again on October 19, 2007. Yet, no masses were noted on those occasions (*see* Ex. 8, unnumbered page 3; Ex. 9, unnumbered page 2).

Dr. Mahl agreed that a complete diagnostic evaluation was needed for a patient that complained of rectal bleeding for four to six weeks, regardless of the findings of a digital rectal exam. Dr. Chait also agreed, noting that frank red blood and rectal bleeding already had been observed and documented. "We've gone beyond the rectal examination" in this case.

Dr. Mannava agreed that the cause or source of rectal bleeding could be anywhere in the GI tract, including the stomach or the esophagus. The AHR entry reflects the doctor's "targeted history" gleaned from the follow-up questions he asked about the patient's subjective complaints in order to help identify the cause/source. Claimant did not report any hematemesis (i.e., vomiting blood), any prior history of peptic ulcers (which can bleed and also cause heart burn), and was not taking any non-steroidal anti-inflammatory drugs (which can sometimes cause bleeding) (*see* Ex. 5, p. 14). The doctor agreed that these answers were "pertinent negatives" that pointed away from an upper GI bleed.

At the same time, Dr. Mannava agreed that his note does not include other information that would be important in assessing a patient with rectal bleeding. For example, the color of the stool is not noted, even though it could help identify the source of the blood. Black stool occurs when blood interacts with digestive juices in the stomach, and is indicative of an upper GI bleed. Generally, frank red blood in the stool suggests a source lower in the GI tract. Only a massive upper

GI bleed would produce frank red blood because, in such cases, there is not enough time for the chemical reaction to change the color of the blood from red to black. Dr. Mannava agreed that such cases are life threatening situations that require immediate emergency treatment in a hospital. Dr. Mahl, likewise, said it would be a "medical emergency" caused by "very rapid bleeding," and "911" should be called. Dr. Chait agreed, noting that Claimant would have "massive bleeding" if the source of the frank red blood was from peptic ulcer disease and that Mr. Upsher would have needed to be in a hospital intensive care unit. Dr. Mannava did not consider Claimant's condition to be life threatening, however, in part because the CBC hemoglobin results were within normal limits.

At the same time, on February 13, 2007, Dr. Mannava did not know the cause of Claimant's rectal bleeding, noting in the AHR that it was of questionable origin (*see* Ex. 5, p. 14 ["rectal bleeding (?) etiology"]). He testified that there could be many causes for intermittent rectal bleeding in addition to cancer, including hemorrhoids, peptic ulcer disease, diverticulitis, anal fissures, and ulcerative or infectious colitis. Dr. Mannava also agreed, however, that the absence of black stool would tend to minimize the likelihood that peptic ulcer disease was the source of Mr. Upsher's bleeding. Dr. Mahl agreed and thought it was "highly unlikely" that Claimant's bleeding was associated with peptic ulcer disease. Dr. Ramineni also said that black stool usually was indicative of bleeding higher up in the GI tract, attributable to conditions such as peptic ulcer disease. He said it usually did not indicate cancer of the colon.

Dr. Mannava also agreed that abdominal pain is a prominent sign of diverticulitis, yet Claimant reported no tenderness or abdominal pain. Dr. Mannava maintained, however, that it still had to be considered. He also agreed that ulcerative colitis often is accompanied by pain, diarrhea, and frequent bowel movements, although he said that bleeding sometimes can be the sole symptom.

Claimant did not report the most prominent sign of anal fissures, pain upon defecation. Dr. Mannava saw nothing in the record that would have caused him to consider constipation as a source of the bleeding.

Nevertheless, Dr. Mannava's "differential diagnosis," the medical process of eliminating probable/possible causes of a condition, contained in the AHR entry, was to rule out ("R/O") peptic ulcers and hemorrhoids as the culprit (Ex. 5, p. 14). He did not list colon cancer as another condition to be ruled out. Thus, Dr. Mannava further agreed that he would have told Mr. Upsher at the conclusion of the February 13, 2007 examination that he might have a peptic ulcer or hemorrhoids, but the doctor would not have told him that he also might have colon cancer. Mr. Upsher said that Dr. Mannava told him that he had hemorrhoids. Dr. Mahl agreed that there is a specific risk or hazard in advising a patient that his rectal bleeding is secondary to hemorrhoids before completing the necessary lab work because the patient may believe, erroneously, that he can self-treat the condition. Moreover, a patient may misapprehend it if the bleeding stops, and believe that the condition has resolved itself.

Dr. Mannava did not list colon cancer, even though he agreed, at trial, that it had to be considered as part of the differential diagnosis in any case where a patient complained of rectal bleeding for four to six weeks. He further agreed that good and accepted practice required that a colonoscopy or sigmoidoscopy be performed, although he disagreed that it was necessary to order tests after his first examination of a patient. Rather, Dr. Mannava wrote in Claimant's AHR to "consider endoscopy studies if no improvement in near future" (Ex. 5, p. 14). Yet, at trial, Dr. Mannava also agreed that he had planned to order the studies, including a colonoscopy, within the next 30 days, and regardless of whether or not Mr. Upsher's condition improved. Because bleeding

ulcers and cancers sometimes bleed only intermittently, an improvement would neither prove that the condition had resolved itself, nor would it answer the question of where the bleeding originated.

NP Ferguson's differential diagnosis, by contrast, differed from Dr. Mannava's and included hemorrhoids, colon cancer, and an upper GI bleed. NP Ferguson discounted the likelihood of the last option, however, because stool would have been black and tarry in an upper GI bleed. At trial, Dr. Mannava said that he agreed with NP Ferguson's differential diagnosis, and he further agreed that it was essential that a specific follow-up appointment be scheduled to resolve a differential diagnosis that included both hemorrhoids and cancer.

Moreover, Dr. Mannava agreed that the decision not to order tests because it was his first examination of Mr. Upsher, and the further intention he expressed to order such tests within 30 days, whether or not Claimant's condition improved, both presupposed that a second visit would occur. He further agreed that it was his responsibility to direct that a follow-up appointment be scheduled and that it was essential that Claimant be seen again in connection with his complaint of rectal bleeding. He also agreed that it would be a departure from good and accepted practice for anyone to deny a request for a GI consultation to a patient reporting rectal bleeding with frank red blood for four to six weeks. Dr. Chait, similarly, opined that it was a departure from good and accepted practice for Dr. Mannava not to have scheduled a follow-up appointment.

Nevertheless, Dr. Mannava ordered no tests, requested no referrals for a colonoscopy/endoscopy concerning Claimant's complaint of rectal bleeding, and did not direct that a follow-up visit be scheduled (because he failed to note "F/U" in the AHR entry [*see* Ex. 5, p. 14][4]).

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[4] RN Visalli agreed that a nurse would not schedule a follow-up appointment as a result of Dr. Mannava's February 13, 2007 AHR entry.

In fact, the doctor never examined Mr. Upsher again. Claimant testified that Dr. Mannava did not direct him to return, or say that he should utilize sick call if his condition persisted, nor did Dr. Mannava indicate to Mr. Upsher that he was ordering any tests. Dr. Mannava testified that Claimant's complaints of rectal bleeding in and before February, 2007 were "related" to his subsequent diagnosis of colon cancer, although he was unable to say whether or not a colonoscopy, if one had been performed in February, 2007, would have revealed the cancer.

Dr. Chait stated that the standard of care for Mr. Upsher required that a referral be made to a gastroenterologist for a colonoscopy given his history of rectal bleeding for four to six weeks and positive Guaiac tests. Dr. Chait further stated that Dr. Mannava's failure to refer Mr. Upsher for such a GI consultation was a departure from good and accepted practice. As previously noted, Dr. Mahl believed that a colonoscopy already was required on account of the three positive results from the stool Guaiac test.

March 5, 2007

Claimant was seen at sick call by RN Visalli on March 5, 2007. While his note stated that Mr. Upsher presented with complaints of cold symptoms, the nurse prescribed Tucks (Ex. 5, p. 14). Claimant testified that he told the nurse that he was still experiencing rectal bleeding. Tucks are medicated pads that RN Visalli said he would dispense to address hemorrhoid symptoms, but agreed that they never are used for cold symptoms. The nurse said that he might, or might not, ask why a patient wanted Tucks, depending on how busy a day it was, but that he would have noted any subjective complaint by Claimant of blood in the stool and referred him for follow-up with a physician. Dr. Mannava said that the only condition indicated in Claimant's AHR that would be treated with Tucks was hemorrhoids. Dr. Chait again opined that it was a departure from good and

accepted practice for RN Visalli not to refer Claimant to be evaluated by a physician, given Claimant's documented history of rectal bleeding. As noted above in connection with Claimant's treatment on January 4, 2007, Dr. Mannava said it is a departure from good practice for a nurse not to record a patient's complaint of rectal bleeding in the AHR. He and Dr. Mahl each additionally indicated it is a further departure not to refer such a patient to a physician.

Mr. Upsher said that the Tucks pads that were dispensed to him on March 5, 2007 was the last time his complaint about bloody stool was discussed or treated at Mid-State. Claimant testified that he intermittently experienced rectal bleeding during the remainder of his incarceration at Mid-State, but did not seek any further medical treatment. He took Dr. Mannava at his word when he said that Mr. Upsher had hemorrhoids so he dropped the matter. Dr. Mahl said that the lack of further complaints of rectal bleeding might put hemorrhoids a bit higher on his differential diagnosis and colon cancer a bit lower, but it would not cause him to strike colon cancer from the list altogether.

April 1, 2007

A comprehensive medical summary ("CMS") form was prepared which, Dr. Mannava agreed, is done before an inmate is transferred to another facility, or released from State custody (*see* Ex. 5, pp. 15-18). It notes Claimant's complaint of "recent rectal bleeding," but observes that lab results were within normal limits (*id.*, p. 15). Dr. Mannava agreed that the entry suggests that the condition had been resolved and, thus, was incorrect insofar as all three of the occult stool samples were positive for blood and, thus, abnormal. The CMS form bears a handwritten note that Mr. Upsher should follow-up with a doctor, but it does not indicate a time frame, or the condition that required further medical attention (*id.*, p. 18). No medical appointments were scheduled by DOCS (*see id.*, p. 17).

[* 16].

May 1, 2007

Dr. Ramineni has worked full time as Mid-State's health services director since 2001 and began treating Claimant in July, 2006. He is board certified in internal medicine and pediatrics. Dr. Ramineni's May 1, 2007 AHR entry concerning Claimant's treatment for hypertension does not reference anything about Mr. Upsher's complaints of rectal bleeding, or any need for a colonoscopy (Ex. 5, p. 19). Dr. Mannava and Dr. Ramineni each agreed that the policy and practice at Mid-State was that, when doctors treated a patient for a specific ailment, such as hypertension, they would review only those medical notes in the AHR that related to that specific problem. Thus, Dr. Ramineni neither would have had any occasion to review Dr. Mannava's February 13, 2007 AHR note about the possible need for a colonoscopy, nor would he have had cause to ask Mr. Upsher questions about rectal bleeding, hemorrhoids, or peptic ulcer disease.

May 31, 2007

Dr. Mannava agreed that no review of, or inquiry into, Claimant's complaints of rectal bleeding would have been made during the May 31, 2007 sick call visit about Mr. Upsher's request for new eyeglasses (*see* Ex. 5, p. 19).

June 6, 2007

RN Visalli reviewed Claimant's medications in contemplation of Mr. Upsher's release to parole supervision (*see* Ex. 5, p. 20). The nurse said that he would not have reviewed prior AHR notes, or checked to see if there were any pending lab results, as part of that exercise. Dr. Mannava agreed that the nurse would not meet with the patient at that time so that there would be no opportunity for Claimant to complain about his bleeding condition. Dr. Chait opined that it was a departure from good and accepted practice to fail to review the charts of a patient leaving the care

of a physician in order to ascertain if any follow-up care was required or if any issues needed to be highlighted for the patient.

June 8, 2007

As with his prior treatment, Dr. Ramineni's follow-up appointment with Mr. Upsher on June 8, 2007 relating to his hypertension issues would not have included a review of Dr. Mannava's February 13, 2007 AHR entry. Nevertheless, the entry records that Claimant requested a "cathartic," which Dr. Mannava and Dr. Chait each said meant a stool softener, and one was prescribed to him. The June 8, 2007 visit was Claimant's last medical appointment at Mid-State before he was released from State custody. Dr. Mannava agreed that his plan to consider ordering a colonoscopy for Mr. Upsher remained, unread, in Claimant's medical chart.

CLAIMANT'S CONDITION WORSENS AFTER HIS RELEASE

Mr. Upsher testified that he has no relatives so that, when he was released from prison, he was homeless, living on the streets, in subways and shelters, and, occasionally, with a friend in The Bronx for a few days at a time. Claimant said that he did not have a private doctor or medical insurance and no one at Mid-State told him that he needed to seek further treatment after he left prison concerning his complaints of rectal bleeding or blood in the stool. He also said that, typically, he does not take his medications when he is living on the street.

July 20, 2007

Claimant presented at Bellevue Hospital's emergency room ("ER") on July, 20, 2007, because he had a nose bleed and had bloody stool (*see* Ex. 8, unnumbered page 1). The ER record notes that Mr. Upsher complained that he had been experiencing "BRBPR" (i.e., bright red blood per rectum) for the past seven months or, in other words, since about January, 2007 (*id.*, unnumbered

page 2). The record does not indicate that Mr. Upsher complained of any abdominal pain. He was told to come back to see a doctor a week later, but said that he was not given a reason why. The ER record, on the other hand, notes diverticulosis and colon cancer as concerns that prompted the second appointment (*see id.*). Mr. Upsher said that he did not keep that appointment because he had no money and it was hard to get to the hospital from The Bronx. Moreover, by that time, the bleeding had stopped. Claimant said that he still thought he had hemorrhoids.

Dr. Mahl opined, however, that Claimant's failure to return to Bellevue in July for follow-up testing did not impact, in any meaningful way, the ultimate outcome of his diagnosis and treatment. "It would be unlikely that the delay [from late July to late October before testing commenced] made a significant biological or clinical difference" that might have allowed Claimant's colon cancer to be identified while it still was at an earlier stage. By contrast, he said that there would have been at least "some" greater possibility of discovering Mr. Upsher's condition at an earlier stage had the testing, instead, begun in January, 2007.

October 19, 2007

Mr. Upsher returned to the Bellevue ER on October 19, 2007 complaining of "loose bowel movements" and "blood in [his] stool" since December, 2006, along with abdominal pain (Ex. 9, unnumbered pages 1 and 2). Claimant testified that, by then, his condition was "a lot different than [it had been] in July." Mr. Upsher said "the blood in my stool got real bad. I had stomach pains. I couldn't hold my bowels [anymore,] I was totally wrecked," with at least episodic periods of incontinence. He said that he had not had stomach pain when he was at Mid-State, but by October it was "unbearable."

October 29, 2007

Mr. Upsher visited Bellevue's GI clinic on October 29, 2007 (*see* Ex. 15). The note indicates that Claimant again complained of "BRBPR," this time for one year, meaning that he would have been experiencing symptoms since about October, 2006 (*id.*). The GI clinic note further states that the container of stool Mr. Upsher brought with him "looks like tomato sauce" and lists the differential diagnosis as "hemorrhoids, diverticulosis, malignancy, AVMs [arteriovenous malformations]" (*id.*). Mr. Upsher said that the medical staff examined him, told him he might have cancer, and scheduled an appointment for him to see a specialist and to have an endoscopy and colonoscopy. An endoscopy/colonoscopy was performed in early November, 2007 (*see* Ex. 17, pp. 799, 806).

Dr. Mahl did not think Claimant had complained about frequent bloody bowel movements when he was at Mid-State and, although he thought it "might be some evidence of advancing disease," he did not agree that the more frequent bloody bowel movements Claimant reported in October, 2007 was a definitive indication that Mr. Upsher's cancer had grown worse.

Dr. Bottino, on the other hand, said that Claimant's recorded complaints at that time of weight loss in recent months, diffuse abdominal pain, and waking several times each night for bowel movements, all were consistent with a more advanced, higher grade cancer. He, likewise, regarded Mr. Upsher's complaints, during his visits to Bellevue, of increasingly more frequent bloody bowel movements, as evidence that Claimant's condition was increasing in severity and that the tumor was expanding rapidly (*see* Ex. 9, unnumbered pages 1 and 2 [October 19, 2007, Claimant reported between 4-8 bloody bowel movements per day (*see also*, Ex. 17, p. 802)]; Ex. 15 [October 29, 2007, 10 per day]; Ex.17, p. 365 [January 24, 2008, 15-20 per day]).

December 17, 2007 Colonoscopy and Biopsy

Claimant kept the follow-up appointment at Bellevue, which was delayed until December, 2007, after his medicaid status was resolved. Dr. Bottino did think that delay was problematic and he did not understand why Bellevue failed to treat him more quickly.

As noted above, the procedure report of the December 17, 2007 colonoscopy indicates that biopsies were taken from a "[n]early circumferential rectal mass" located 18-25 cm from the anus (*see* Ex. 10). The subsequent biopsy report determined that Mr. Upsher had an "invasive, moderately differentiated" "adenocarcinoma" (Ex. 3). A January 24, 2008 Bellevue ambulatory care chart includes a clinical note that Claimant had "near obstructing sigmoid cancer" (Ex. 17, p. 773). Dr. Bottino said that was consistent with Mr. Upsher's complaints of up to 20 bowel movements per day. By contrast, he saw no evidence that Claimant had any such obstruction while he was at Mid-State because of the absence of similar complaints of pain, diarrhea, weight loss, frequent bloody bowel movements, etc. in the prison medical records.

The Colon and Cancer Staging

The colon is a round, tube-shaped organ, sometimes likened to a garden hose. The inside layer or surface of the colon, called the mucosa, is composed of glandular cells that interact with the food that comes through the colon to convert it into feces. Next, there is a muscular sheath, called the muscularis, that contracts in order to propel the contents of the colon. Finally, on the outside of the colon is a containing membrane called the serosa.

Dr. Mahl and Dr. Bottino each said that colon cancers are graded on three factors: the size of the tumor and how far it has penetrated into the wall of the colon muscle (the "T" status); whether and, if so, the number of lymph nodes that have been implicated, to see if the cancer has spread

outside the bowel (the "N" status); and whether metastasis has occurred so that colon cancer cells have spread to organs far from the colon, such as to the liver or lung (the "M" status).

Both doctors said that each status is further assigned numbers in ascending order of severity, which Dr. Bottino outlined in some detail. T1 tumors are confined within the mucosa. T2 tumors extend into the muscularis. T3 tumors penetrate the serosal boundary and go into the pericolonic fat that surrounds the colon. T4 tumors are ones that have metastasized and spread to another organ. Regarding lymph nodes, Dr. Bottino said that stage N1 denoted involvement of only one or two localized nodes that are adjacent to the tumor. N2 means that the tumor has spread to more distant nodes and is further classified according to the number of nodes implicated (N2a [fewer than four nodes], N2b [four to six nodes], and N2c [seven or more]).

Dr. Bottino then explained that the T, N and M status ratings are analyzed collectively and the cancer is assigned an overall stage, again in ascending order of severity, from I to IV, so that the prognosis decreases as the stage increases. He called the staging system "the most important aspect of prognosis and growth" and all treatment is based upon that staging system. Stage I indicates a small tumor, early in its development, that is "contained by the muscularis within the mucosa" (e.g., a T1 tumor), and which has not spread to the lymph nodes, or other organs. In Stage II, "increased local growth" is occurring, "pretty much to a T3" tumor, again with no lymph node or other organ involvement. At Stage III, the tumor, regardless of its T status, has metastasized into the lymph nodes, and, at Stage IV, it has metastasized into another organ. Dr. Bottino noted that most colon cancers begin as microscopic, benign polyps in the mucosa, which then become invasive.

Dr. Mahl and Dr. Bottino each said that surgery is the only recommended treatment for a Stage I colon cancer, without the need for chemotherapy, and that the same regimen generally applies in cases of Stage II colon cancer as well.

February 1, 2008 Surgery

Mr. Upsher had recto-sigmoid colon resection surgery on February 1, 2008 (*see* Ex. 17, pp. 765-771). In Dr. Bottino's view, the surgery was properly performed. The Bellevue pathology report states that Mr. Upsher had an "invasive adenocarcinoma of [the] colon, moderately differentiated" and that the "tumor extensively invades the muscularis propria and focally extends into the subserosal fat" (Ex. 7, first unnumbered page). The report further states that "[f]ive out of twenty[-]nine pericolic lymph nodes are positive for metastatic carcinoma (5/29). AJCC pathologic stage: T3[,] N2[,] MX" (*id.*).

Dr. Bottino explained that the report describes an invasive cancer of the colon's glandular tissue (adenocarcinoma) that is beginning to lose its glandular features or appearance (moderately differentiated) with cancer discernable in "clumps and strings." Dr. Bottino further testified that "AJCC" refers to the American Joint Commission on Cancer. Dr. Bottino reiterated that, in general, T3 tumors are ones that "penetrate the serosal boundary and go into the pericolonic fat." In Mr. Upsher's specific case, Dr. Bottino said it was graded a status T3 tumor because it had broken through the serosa "in a small area" (i.e., focally). Dr. Bottino said that the focal nature of the extension into the serosa indicated that the incursion had "just started." If the cancer was confined to the extensive invasion of the muscularis described in the report, he said it still would have been a status T2 tumor.

Dr. Mahl, likewise, agreed that the report indicates that the cancer was moderately aggressive, had invaded the wall of the colon muscle (muscularis propria) extensively and diffusely, including, in some spots (focally), the fatty tissue (the subserosal fat) that surrounds the muscle. He did not agree, however, that the report suggests that the penetration of the muscle wall into the fatty tissue was a fairly recent event. Rather, it was Dr. Mahl's opinion that, while "possible," he thought it "unlikely" that the spread of the cancer into the patient's lymph nodes occurred during the 10-month period between his treatment at Mid-State and the biopsy performed at Bellevue.

Dr. Mahl said that metastasis to the lymph nodes is a very different matter than a spread to more distant organs since the latter case means that it has become a Stage IV cancer which is "bad," the patient "can't be cured," and most often the cancer has spread to the liver. Dr. Mahl believed that the implication of five lymph nodes in Mr. Upsher's case, in part, was a consequence of the surgeon's success in removing a large number (29) of nodes. Even so, Dr. Mahl thought that five nodes is "kind of on the limit" of the stage being downgraded.

Dr. Bottino also said that 29 nodes was a large specimen. He said that it was an N2 tumor both because more than four lymph nodes were implicated and because those nodes were located more distant from the tumor and not right nearby. Rather than being on the cusp of a downgrade, however, as Dr. Mahl stated, Dr. Bottino testified that Claimant's cancer was just shy of being upgraded from a Stage III to a Stage IV cancer at the time of surgery, noting that "at this point it's starting to grow and spread pretty rapidly." Dr. Bottino also thought that the focal breakthrough indicated that the cancer had advanced from Stage II to Stage III in a short time period, perhaps as little as one month.

Chemotherapy Treatment Post Surgery

Claimant was arrested on February 6, 2008, the day he was discharged from Bellevue Hospital, in connection with an incident that occurred before his cancer diagnosis was made, and he was sent to Riker's Island. Mr. Upsher related that he was transported from Riker's Island back to Bellevue some time later to discuss the results of his surgery. Claimant learned that he had Stage III colon cancer and was told he was "in bad shape" and that he "definitely need[ed] chemotherapy." Mr. Upsher said that he "thought [he] was going to die."

Claimant received twelve cycles of chemotherapy at Bellevue, over the course of six months, beginning in March, 2008. Dr. Bottino said that schedule was very routine for Folfox, the type of chemotherapy Mr. Upsher received. Mr. Upsher described the chemotherapy regimen he followed. He would spend 72 hours at Bellevue being tested and receiving treatment. Then, he would be held at Bellevue for several more days before being returned to Riker's Island. Claimant said that the chemotherapy made him feel awful. "I'll never forget," Mr. Upsher said, recalling the chemotherapy, "that was Hell." As the chemotherapy infusion itself was being administered, Claimant said that it "felt like fire" was going into his veins. "That stuff is poison." Afterwards, he had no strength, could not eat, had mouth sores, nausea, rashes, was unable to get out of bed without assistance, and had shaking and dizzy spells. He suffered, by turns, bouts of constipation and then diarrhea. He "begg[ed]" the medical staff to stop the treatments, but was told "either take this chemo, or die." "I never felt [anything] like that in my life." Mr. Upsher said that he would just start to feel a little bit better when it was time to begin the next cycle of chemotherapy.

Claimant also developed numbness and tingling in his fingers and toes which continued during the whole period he received chemotherapy, as well as for some two-and-a-half years

thereafter (*see* Ex. 18, p. 200). He still feels a "little" bit of numbness/tingling in his fingers, but "nothing like it was." He also developed a couple of blood clots in the area where the chemotherapy was administered. Claimant could not move his arm, which turned black and blue, and was put on blood thinners. He developed an infection, had pains in his flanks and back, and was told he had chronic/acute kidney failure. Mr. Upsher said that he "was afraid I was going to die. I was always crying. I was always shaking, and I was always praying to the Good Lord, please pull me through this."

Dr. Bottino testified that Claimant's documented complaints all are common consequences associated with Folfox chemotherapy (*see* Ex. 17 [Bellevue Hospital Center records], pp. 107, 185, 558, 807 [abdominal pain, cramping, and/or distension and/or gas], 37, 70, 118, 182, 475, 529, 553, 554, 556, 558, 717, 739, 743, 746, 751, 780 (13 days), 807, [diarrhea and/or constipation and/or hemorrhoids], 751 [fatigue], 70, 456, 529, 533, 746, 751, 807, 1032, 1035, 1074 [nausea and/or vomiting], 751, 1035 [mouth sores/unable to eat], 475, 1052 [pain at sites of intravenous lines], 37, 38, 739 [nerves tingling]; Ex. 18, p. 200 [numbness/nerves tingling]; *see also* Ex. 19 [Riker's Island medical records while receiving chemotherapy], pp. 11, 17, 19, 29, 45, 72, 73, 262, 477, 483, 490, 506, 527, 529, 530, 549, 565, 566; Ex. 18 [DOCCS medical records after completion of chemotherapy], pp. 35, 59, 105, 186, 200, 260, 262, 263, 268).

Dr. Bottino further said that there are long-term complications from chemotherapy, which, he noted, is a "cellular poison" that attacks everything, not just cancer cells. Moreover, he said that Folfox is a platinum-based regimen and that platinum drugs generally cause significant neuro-toxicity, renal toxicity, and, generally, reduced longevity. He said that chemotherapy recipients have a 3-7% increased risk of developing leukemia. Dr. Bottino said that the numbness/tingling is "the

first sign of developing neuro-toxicity from platinum," which will improve over time, but "almost never goes away completely." Likewise, he also said that the unpleasant, hot and burning sensation described by Claimant when the chemotherapy was administered was "very common."

Dr. Bottino further noted that, in July, 2008, Mr. Upsher experienced acute renal failure (*see* Ex. 17, p. 558 ["ARN"]) which progressed into acute tubular necrosis (*see id.*, p. 743 ["ATN"]). Dr. Bottino said that this was an indirect consequence of the chemotherapy treatment. Dr. Bottino said that ATN meant that some of the tubular structures in the kidney that filter the body's impurities were deprived of oxygen and died. He further said that those structures usually do not regenerate. He also noted that chemotherapy is a nephrotoxin and that, combined with Claimant's history of hypertension (the main cause of kidney failure), means that Mr. Upsher could be at an increased risk of kidney disease and damage in the future. Dr. Bottino opined that, if surgery had been performed on Claimant when he was at Mid-State, it would have been to remove either a polyp or a lesser-stage cancer and, thus, he would have "completely avoided" the pain and suffering described above that resulted from the chemotherapy.

At the same time, Dr. Bottino agreed that it was a good sign that Claimant denied having diarrhea, nausea, vomiting, abdominal distention, bloating, or mouth sores when he visited Upstate Medical Center in January, 2009, some four months after his chemotherapy regimen ended (*see* Ex. 18, pp. 200-201). "His only complaint is of constipation that has been persistent since the surgery," but there was "no rectal bleeding" (*id.*, p. 200). Dr. Bottino agreed that Mr. Upsher's constipation could be a side effect of his hypertension medication, although he thought it more likely that it was a complication of the surgery, in part because there was no change in Mr. Upsher's treatment regimen for high blood pressure. As noted above, Claimant had some numbness and tingling of the

fingers and toes. In general, however, the note stated that Claimant was well nourished and did not show evidence of any jaundice, pale pallor, oral lesions, or neck masses. Dr. Bottino said that he would not expect the patient to have acute complaints related to chemotherapy three or four months after the treatment had ended. Dr. Bottino agreed that there is no report of anxiety in the note. He further agreed that patients do tend to become less anxious with the passage of time, provided there has not been any recurrence of cancer.

Nevertheless, Mr. Upsher agreed that he remains anxious since his cancer diagnosis (*see* Ex. 18, pp. 144, 201; Ex. 19, pp. 301, 310). "Any time I get a stomachache, the first thing that comes to my mind [is], the cancer's coming back." He thinks about it "a whole lot." If he gets hemorrhoids, or sees any blood in his stool, he worries that the cancer has returned. Doctors told him that there is no cure for his cancer. Rather, the best that can be done is to keep it in remission. Dr. Bottino said that Mr. Upsher's expressions of anxiety, and fear of a recurrence of his disease, also are quite common and reasonable responses among cancer patients.

Claimant was returned to State custody and sent back to Mid-State in December, 2008. During his current incarceration, Mr. Upsher continues to be treated periodically. Claimant said that he has not had a CT scan within the last year, however, even though the oncologist told him he would have one every year, and should have had one in April, 2012. Mr. Upsher said that, at present, he feels "kind of scared" because he knows he is "on borrowed time."

LAW

When the State engages in a proprietary function, such as providing medical care, it is held to the same duty of care as private actors engaging in similar functions (*Schrempf v State of New York*, 66 NY2d 289, 294 [1985]; *see Sebastian v State of New York*, 93 NY2d 790, 793 [1999]).

Thus, it is "fundamental law that the State has a duty to provide reasonable and adequate medical care to the inmates of its prisons" (*Rivers v State of New York*, 159 AD2d 788, 789 [3d Dept 1990], *lv denied* 76 NY2d 701 [1990]). Medical malpractice "is simply a form of negligence [and] no rigid analytical line separates the two" (*Scott v Uljanov*, 74 NY2d 673, 674 [1989]; *see Maki v Bassett Healthcare*, 85 AD3d 1366, 1367 [3d Dept 2011], *appeal dismissed* 17 NY3d 855 [2011], *lv to appeal dismissed in part, denied in part* 18 NY3d 870 [2012]). To establish a medical malpractice cause of action, Claimant must prove that Defendant (1) departed from the requisite standard of medical care, and (2) that such departure was a substantial factor in causing the injury (*Helfer v Chapin*, 96 AD3d 1270, 1272 [3d Dept 2012]; *Carter v Tana*, 68 AD3d 1577, 1579 [3d Dept 2009]).

Where, as here, Claimant asserts that his injuries resulted from some omission or delay on Defendant's part, Defendant's negligence can be shown to have been a substantial factor in causing those injuries if it deprived Claimant of a "substantial possibility" of avoiding them (*see Wild v Catholic Health Sys.*, 85 AD3d 1715, 1717 [4th Dept 2011], *affd* 21 NY3d 951 [2013]; *Cannizzo v Wijeyasekaran*, 259 AD2d 960, 961 [4th Dept 1999]; *Marchione v State of New York*, 194 AD2d 851, 854-855 [3d Dept 1993]; *Brown v State of New York*, 192 AD2d 936, 937 [3d Dept 1993]; PJI 2:150 [XII. Causation; A. Loss of Chance]).

"An award for pain and suffering is inherently a subjective inquiry, not subject to precise quantification, and generally presents a question of fact" (*Leto v Amrex Chem. Co., Inc.*, 85 AD3d 1509, 1511 [3d Dept 2011], quoting *Petrilli v Federated Dept. Stores, Inc.*, 40 AD3d 1339, 1343 [3d Dept 2007]). "Moreover, factors to be considered in evaluating such awards include the nature, extent and permanency of the injuries, the extent of past, present and future pain and the long-term effects of the injury" (*Nolan v Union Coll. Trust of Schenectady, N.Y.*, 51 AD3d 1253, 1256 [3d

Dept 2008], *lv denied* 11 NY3d 705 [2008]). The trial court's award will not be disturbed unless it "deviates materially from what would be reasonable compensation" (CPLR § 5501 [c]). In awarding damages for Claimant's past and future pain and suffering, it is proper for the Court to take judicial notice of the life expectancy tables set forth in Appendix A to the Pattern Jury Instructions (*see Giambrone v Israel Am. Line*, 26 Misc 2d 593, 600 [Sup Ct, NY County, 1960]; *Hancock v Hull Realty Corp.*, 1994 WL 16459400 [Sup Ct, Bronx County, 1994]; PJI 2:281).

DISCUSSION

Upon consideration of all the evidence, including a review of the exhibits and listening to the witnesses testify and observing their demeanor as they did so, the Court finds that Claimant met his burden, and established by a preponderance of the credible evidence his claim of medical malpractice against the State. The Court finds Defendant 100% liable.

Witness Credibility

Each of the witnesses provided generally sincere and forthright testimony, although the Court found the testimony of RN Visalli to be defensive, at times bordering on evasive. Moreover, while sincere, in places, the Court found Dr. Mannava's testimony to be confusing and/or inconsistent. Mr. Upsher, on the other hand, spoke compellingly about the pain and suffering he endured during his illness, surgery, and post-operative chemotherapy. The Court found each of the three expert witnesses to be knowledgeable, earnest, articulate, and informative. However, with respect to critical questions concerning the development and rate of growth of Mr. Upsher's cancer, the Court found Dr. Bottino to be the most persuasive. The State's own expert, Dr. Mahl, agreed that, while a gastroenterologist, like himself or Dr. Chait, is involved in the initial diagnosis of colon disease and the removal of polyps, typically, it is other specialists, such as surgeons and oncologists, who decide

how much of the colon needs to be removed and whether the patient requires chemotherapy. He further agreed that an oncologist, which Dr. Bottino is, may have greater expertise than Dr. Mahl does with regard to how invasive cancer cells divide and change. Ultimately, the Court found Dr. Bottino's opinions to be more authoritative and supported by the most concrete and persuasive analysis.

Factual Determinations

While Mr. Upsher sometimes gave other dates, the Court finds, as a matter of fact, that Claimant first experienced blood in his stool in late December, 2006, or very early January, 2007. That time line comports best with the lack of any such complaints being noted in the AHR of his November, 2006 physical examination and with Claimant's other statements that he presented at sick call as soon as he noticed bloody stools.

The Court further finds that Claimant complained about rectal bleeding during his January 4, 2007 sick call visit, being persuaded that the AHR notation reflects responses to the nurse's targeted questions that were prompted by complaints about rectal bleeding.

The Court also finds that Dr. Mannava did not tell Claimant that he might have colon cancer on February 13, 2007. Dr. Mannava said that he would not have done so and Claimant said that he was told only that he had hemorrhoids.

Finally, the Court credits Mr. Upsher's testimony and finds that he told RN Visalli that he was still experiencing rectal bleeding at the March 5, 2007 sick call visit.

Deviations from the Requisite Standard of Care

In the Court's view, there were manifold, unfortunate, and significant departures from the requisite standards in the medical care Claimant received while at Mid-State.

The Court finds that good practice required that the nurses note Mr. Upsher's complaint about rectal bleeding explicitly in the January 4, 2007 and March 5, 2007 AHR entries. On both occasions, the Court further finds that Mr. Upsher should have been referred for evaluation by a physician as a result of those complaints. The failure to do so in each instance constituted a departure from the requisite standard of care.

The Court further finds that RN Visalli departed from good and accepted practice on February 1, 2007, when he failed both to schedule a follow-up appointment with NP Ferguson, as directed, and to advise Mr. Upsher to return to the infirmary if he experienced further rectal bleeding. An additional deviation occurred when NP Ferguson failed to request a colonoscopy for Mr. Upsher after the positive results of the stool Guaiac test and lab work were received and reviewed.

The Court finds that several significant departures from the requisite standard of care occurred on February 13, 2007. Dr. Mannava knew that all three of Claimant's stool Guaiac samples had tested positive. He knew that Mr. Upsher reported that he had been experiencing rectal bleeding for a period of four to six weeks. He should have known that the patient's subjective complaint was confirmed by the nurse's direct observation of frank red blood in the stool on January 31, 2007. The Court concludes that the requisite standard of care required that Dr. Mannava include colon cancer in his differential diagnosis, that he promptly request a referral for Mr. Upsher to have both a GI consultation, as well as a colonoscopy/sigmoidoscopy, and that he schedule an additional appointment in order to monitor Claimant's condition until a definitive diagnosis could be made. In each case, Dr. Mannava's care and treatment of Mr. Upsher departed from that standard.

In fact, at trial, Dr. Mannava agreed that colon cancer had to be considered in this case. Yet, he left it off his differential diagnosis even as he pursued other possible causes, like peptic ulcer

disease, a condition which Dr. Mannava's own testimony, as well as that of the other doctors and NP Ferguson, establishes was both an inadequate explanation for, as well as a most unlikely source of, the frank red blood that Mr. Upsher was passing.

Accordingly, Dr. Mannava told Mr. Upsher that he might have a peptic ulcer or hemorrhoids, but did not tell him that Claimant also might have colon cancer. Mr. Upsher took Dr. Mannava at his word and did not pursue his complaints about rectal bleeding further after March 5, 2007. As a result, Claimant labored under the mistaken belief, which Dr. Mahl agreed was a risk under such circumstances, that he had hemorrhoids and could address the symptoms by himself and/or that the condition had resolved itself during periods when his bleeding abated.

Dr. Mannava also agreed, at trial, that a colonoscopy or sigmoidoscopy had to be performed in this case. In fact, he further agreed that it would be a departure from good and accepted practice for anyone to deny a request for a GI consultation to a patient, like Mr. Upsher, who was reporting rectal bleeding with frank red blood for four to six weeks. Nevertheless, he did not request endoscopic studies on February 13, 2007. Rather, his AHR note indicates only that they should be considered if Claimant's condition did not improve in the near future. Yet, Dr. Mannava also agreed, at trial, that he planned to order those very same studies, including a colonoscopy, sometime during the next 30 days, whether or not Mr. Upsher's condition improved.

Claimant's refusal to submit to a digital rectal examination on February 13, 2007 in no way vitiates the standard of care applicable in this case. Dr. Mannava, himself, agreed that the tumor discovered by the Bellevue biopsy could not have been detected by his digital examination of the patient. Moreover, as Dr. Chait noted, the confirmation of frank red blood and rectal bleeding by the nurse on January 31, 2007 already superceded any confirmation of Claimant's symptoms that

might have been obtained by a rectal examination. Even Dr. Mahl agreed that Mr. Upsher needed a complete diagnostic evaluation, regardless of the findings of a digital rectal exam.

The Court finds it impossible to reconcile Dr. Mannava's reticence and delay in failing, on February 13, 2007, to request endoscopic studies that he intended to order anyway with the requisite standard of care, which Dr. Mahl agreed requires that a diagnosis be made within 30 days of a patient reporting symptoms.

The consequences of Dr. Mannava's failure to request the studies was compounded by his failure to direct that a follow-up appointment be scheduled. He agreed both that he was responsible for so directing and that it was essential that Claimant be seen again. Dr. Mannava never had another occasion to order the endoscopic studies he deferred on February 13, 2007, however, because he never treated Mr. Upsher again after that date.

Finally, good and accepted practice required that Claimant's medical records be reviewed when he was leaving State custody in order to identify any follow-up care that needed to be brought to Claimant's attention. The Court finds that RN Visalli's review of Mr. Upsher's medications on June 6, 2007 did not meet that standard.

Deviations Substantial Factors in Claimant's Stage III Cancer

The next question, then, is whether those departures from the requisite standard of care were a substantial factor in the severity of the colon cancer that was diagnosed by Bellevue in 2008 and the surgery and chemotherapy that were required in order to combat it. Resolution of that question, in turn, depends upon how quickly the cancer likely developed. While Dr. Mahl testified earnestly, on this key point the Court again found the testimony of Dr. Bottino to be more persuasive. The Court concludes that the serial failures by Mid-State's medical staff, both to refer Mr. Upsher for a

GI consult and to request endoscopic studies promptly, resulted in a delay of many months in the detection and ultimate treatment of Claimant's cancer. That delay deprived Mr. Upsher of a substantial possibility that his condition could have been identified and addressed while it was still a polyp, or at least a lesser-stage cancer. Less invasive surgery would have been required in that case and it would not have required chemotherapy treatment afterwards.

In this regard, the Court was not persuaded by Dr. Mahl's testimony. He testified that colon cancers "don't gallop down the road and advance extraordinarily quickly" and that precursors to cancer, as well as colon cancer itself, can be largely asymptomatic "until it's too late," so that, in all likelihood, Claimant already had Stage III colon cancer in February, 2007. Thus, he opined that Mr. Upsher would have required "the absolute same surgery" and post-operative chemotherapy regimen, both in terms of length and magnitude, and with the same side effects attendant thereto, as he eventually underwent in February, 2008. The Court rejects that opinion.

Dr. Mahl and Dr. Bottino both did agree that mutations in the bowel that are the precursors to colon cancer progress slowly so that it can take a decade or more for a polyp that can be detected by a colonoscopy to become malignant. But, they also agreed that is why screening is done. Thus, Dr. Mahl said that doctors like to look for those precursors (e.g., polyps), as early in the process as possible. In fact, he agreed that the biggest improvements to patient outcomes in a study he participated in at the Buffalo VA came from the utilization of more screening colonoscopies to identify precursors to cancer, and from reducing delays in case management (*see* Ex. 14). He also agreed that delays in managing a case can adversely affect the patient's prognosis and even change the stage of a cancer. Dr. Mahl further agreed that those very delays occurred in Mr. Upsher's case.

By contrast, Dr. Bottino said that, while a malignancy initially may grow slowly, it begins to grow exponentially as it becomes more invasive, and, by Stage III, it "really starts taking off." Moreover, he also said that the rate of growth can vary in individual cases so that it is important to have specific information about the patient in question. Accordingly, Dr. Bottino based his opinion upon his understanding both of the growth rates of colon cancers generally, as well as Mr. Upsher's specific information, including the pathology report, and the findings, complaints, and histories contained in the medical records.

In Dr. Bottino's opinion, it only took a short time for Claimant's malignancy to morph from a Stage II cancer to Stage III. He formed that belief based upon the fact that the incursion into the serosal fat had occurred only focally, rather than more diffusely. He also cited the January 14, 2008 Bellevue oncology note referencing a November, 2007 CT scan that found a 2.2 cm sessile (i.e., flat) lesion (*see* Ex. 17, p. 799). By contrast, the pathology report states that a 6.0 cm necrotic mass was removed during Claimant's February, 2008 surgery (*see* Ex. 7, second unnumbered page). Dr. Bottino said that shows the tumor "grew pretty remarkably big" in just a few months, in a manner consistent with the growth spurts for malignant tumors generally that he had described.

Based on the foregoing, it was Dr. Bottino's further opinion that if a colonoscopy had been performed in January, 2007, it would have revealed either a bleeding polyp, or a Stage I or Stage II colon cancer. He noted that Stage I cancer is treated exclusively by surgery, without the need for chemotherapy and chemotherapy, likewise, is generally not recommended for most Stage II cancer patients. Thus, Dr. Bottino said that the failure to refer Claimant to a physician for a work up in January, February, and, again, in March, 2007, deprived Claimant of a significant possibility of avoiding chemotherapy as part of the treatment regimen for his cancer.

Dr. Bottino said that the prognosis for a patient who has a polyp removed is a 100% cure rate. If, instead, a Stage I cancer was found, he said that it would have been a "much easier surgery" than the procedure Claimant endured in February, 2008, because it would have taken less than half the time, surgeons would not have had to search for nodes, and the tissue plains of the colon would not have been disrupted. As for Mr. Upsher, he would have been stronger, healthier, and better able to tolerate the surgery. The pain and suffering he had to endure would not have been as bad, and the complication rate from the surgery would have been much less. In fact, Dr. Mahl agreed that many of the symptoms Claimant experienced were associated with chemotherapy. He said that "chemotherapy is not fun," but he also thought that Claimant weathered it remarkably well.

It was Dr. Mahl's opinion that Mr. Upsher is clinically cured of his colon cancer. He said that patients who live five years without a recurrence of colon cancer are cured and, at trial, Claimant was two weeks shy of the fifth anniversary of his surgery.

Dr. Bottino agreed that a patient, such as Mr. Upsher, who has survived five years without a recurrence of cancer has had a good result. He also said, however, that patients whose cancer first occurs at an early age have a poorer prognosis in terms of cancer treatment/recurrence. Dr. Bottino also stated that the survival rate for someone, like Mr. Upsher, with status T3 cancer with five positive nodes implicated (which he characterized as a Stage III-B tumor) who has undergone chemotherapy treatment is about 55% after five years and about 30% after ten years. As Claimant's counsel notes, that means that "[i]f 55 out of 100 patients will be alive at the end of [five] years, but only 30 of those patients will be alive at 10 years, [then] 25 of those patients will die in that intervening period," so that "Mr. Upsher's risk of dying over the next five years is almost 50%" (Claimant's Post-Trial Memorandum, p. 48 and fn 15). Dr. Bottino disagreed with Dr. Mahl's

opinion that Claimant was cured, saying that "it is not consistent with the national data" from the AJCC done through National Cancer Institute data banks, which he said is "the national standard for prognosis." In fact, Dr. Bottino said that Mr. Upsher's prognosis was worse than the general Stage III-B data because five of his nodes were implicated. He said that the general prognosis for Stage III-B tumors would be about 40%. He further said that an oncologist could not provide an accurate survival prognosis for Claimant without reviewing the oncology report.

Dr. Bottino further opined that Claimant's numerous hospitalizations from February, 2008 through September, 2008 (*see* Ex. 12 [bills from Bellevue Hospital Center covering most of the dates discussed at trial]) were related to his Stage III-B colon cancer. He did not believe that those hospital stays would have been required had Mr. Upsher's cancer been diagnosed when it was at either a Stage I or a Stage II level.

Dr. Bottino also testified that there are potential long-term complications associated with the surgery Claimant had, including a significant risk of the bowel herniating within itself because of the surgery and the weakening of the colon wall, which could necessitate further surgery in the future. He said that Claimant's persistent complaints of constipation since his surgery (*see* Ex. 18, pp. 35, 59, 105, 186, 200, 262, 263) are a complication that can continue for years, if not the remainder of a patient's lifetime, and would have been "much less" likely if the surgery had been performed in 2007. Likewise, a consultation note from early 2012 indicates that Mr. Upsher had two recent CT scans and a colonoscopy and that "he has chronic constipation and narrowing and edema [of the] sigmoid colon" (Ex. 18, p. 59). Dr. Bottino said this indicates "chronic damage," with persistent "swelling and inflammation around the surgical site" that is consistent with the more extensive surgical plains that were disrupted during the procedure.

The Court credits Dr. Bottino's opinions and the analysis that supports them and concludes that Defendant's departure from the requisite standard of care in failing to address Mr. Upsher's emergent condition by referring him promptly to see a physician, and/or to a GI specialist, and/or to request endoscopic studies, including a colonoscopy, on multiple occasions from the time he first presented with complaints of rectal bleeding in January, 2007 until he was released from State custody in June, 2007, each was a substantial factor in the injury he sustained.

Collectively, they form a cascading chain of errors, which both individually and collectively deprived Mr. Upsher of a substantial possibility of avoiding the development of Stage III colon cancer and the need for surgery and chemotherapy. As Dr. Chait said, "[d]elay in treatment allows for the malignancy to progress. And the longer the wait, the more chance of progression going from an early stage, which can be easily treated, to an advanced stage that requires chemotherapy and additional treatments, if possible, so it becomes a more difficult treatment. So, the longer you wait, the more extensive the disease." Accordingly, the Court finds that Mr. Upsher had, at most, a Stage I or Stage II colon cancer when he was released from State custody in June, 2007.

The Court further concludes that the Stage III cancer that Claimant developed as a result of Defendant's departure from the requisite standard of care resulted in Mr. Upsher having to endure more invasive and complicated surgery than would have been the case if his condition had been treated in a timely manner by the State, as well as debilitating and painful post-operative chemotherapy treatment, which would have been unnecessary had the State acted promptly. The Court also concludes that all the foregoing has adversely affected his long-term prognosis.

The Court finds Defendant 100% liable for Claimant's injuries. It is true that Mr. Upsher did fail to return to Bellevue in July, 2007, which delayed his treatment to some extent. To the Court's

mind, however, Claimant's action is wholly excusable under the circumstances. Mr. Upsher labored under a misapprehension that he had hemorrhoids, a belief fostered in his mind by the medical providers who treated him at Mid-State. Moreover, and in any event, Defendant's expert, Dr. Mahl, was unequivocal that the delay had no meaningful impact on the ultimate diagnosis in this case. It also is true that Claimant's expert thought the delay in procuring Mr. Upsher's biopsy, from the end of October until December, was problematic. There is nothing in the record, however, to suggest that Mr. Upsher was in any way responsible for that delay. Likewise, the record does not establish that anyone else, including but not limited to Bellevue, was negligent in any way, or bears any measure of blame, in connection with the delay. Thus, the Court declines to ascribe any culpability to Mr. Upsher, or any third party, for the injuries Claimant suffered.

Damages

The Court also finds that Claimant has suffered permanent damage to his health as a consequence of Defendant's medical malpractice. In assessing damages for Claimant's past and future pain and suffering, the Court is mindful that Mr. Upsher developed Stage III colon cancer, a more serious condition than existed at the time when the State should have first intervened to address his complaints effectively. As a result, his strength and energy were sapped while he was forced to endure 10 months of pain as his undiagnosed cancer matured. More serious surgery was needed than would have been required in order to combat a lesser stage cancer, or a polyp. He was required to submit to six months of awful, painful, and sickness-provoking, but essential and life-prolonging, post-operative chemotherapy treatment. His future likelihood of additional complications from, and recurrence of, his illness has been increased. His prognosis and longevity have been diminished

significantly from the average remaining life expectancy for a 50 year-old male, which is approximately 28 years, to having, at best, a 50-50 chance of surviving the next five years.

The Court concludes that Claimant endured significant pain and anxiety for an extended period until his surgery and post-operative chemotherapy were completed, and that he continues and will continue to experience pain, discomfort, and anxiety in the future.

CONCLUSION

Based on all the foregoing, the Court finds that Claimant established his case by a preponderance of the credible evidence. The Court awards damages to Claimant in the total amount of $1,200,000, comprised of $800,000 for past pain and suffering and $400,000 for future pain and suffering. The Court finds that sum constitutes fair and reasonable compensation for Mr. Upsher's injuries. No award is made to satisfy any medical liens that may exist (*see* Exs. 12 and 13). No evidence was presented to substantiate any other medical expenses or any lost wages incurred or to be incurred in the future by Claimant. Accordingly, no damages are awarded for either of those items. Defendant is 100% liable for the damages awarded.

In addition, the Court awards Claimant the actual amount of any fee paid to file the Claim, as a taxable disbursement pursuant to Court of Claims Act § 11-a (2).

All motions upon which the Court reserved decision at trial are hereby denied.

All objections upon which the Court reserved determination at trial are now overruled.

The Chief Clerk is directed to enter judgment accordingly.

Albany, New York
January 31, 2014

CHRISTOPHER J. McCARTHY
Judge of the Court of Claims