[Cite as *Billip v. Dept. of Rehab. & Corr.*, 2009-Ohio-650.]

Court of Claims of Ohio

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LAVELLE BILLIP

Plaintiff

v.

DEPARTMENT OF REHABILITATION AND CORRECTION

Defendant

Case No. 2005-01421

Judge J. Craig Wright

DECISION

{¶ 1} Plaintiff brought this action alleging medical malpractice. The issues of liability and damages were bifurcated and the case proceeded to trial on the issue of liability.

{¶ 2} At all times relevant, plaintiff was an inmate in the custody and control of defendant at the North Central Correctional Institution (NCCI) pursuant to R.C. 5120.16. Plaintiff contends that in June 2000 he began complaining to defendant's medical staff, particularly Charles Cloutier, M.D. and Lenzy Southall, M.D., about changes in his bowel habits and rectal pain and bleeding. Plaintiff further contends that those symptoms continued and became progressively worse over the next three years but that NCCI medical providers consistently attributed his complaints to hemorrhoids; that a rectal examination was not performed until February 2003; and that no diagnostic tests such as a colonoscopy or sigmoidoscopy were ordered to rule out other causes for his symptoms. In January 2004, plaintiff was diagnosed with rectal carcinoma. He underwent chemotherapy and radiation treatments, after which an abdominoperineal resection (APR)[1] was performed in conjunction with a permanent colostomy.

{¶ 3} Plaintiff contends that NCCI medical staff failed to properly document his complaints, to recognize the progression of his symptoms and, thus, to timely diagnose his condition. Plaintiff further maintains that, had his condition been timely diagnosed, it would not have progressed to the advanced stage that was present in January 2004, and that the APR and permanent colostomy could have been avoided.

{¶ 4} In response to plaintiff's arguments, defendant asserts that the medical records document that plaintiff first complained of rectal bleeding to Dr. Cloutier on March 21, 2002; that his next complaint was voiced at nurse's sick call on February 12,

[1]APR is an extensive surgery that involves removal of the cancerous growth, the adjacent rectal tissue, and the rectal sphincter, or anus. In addition to the permanent colostomy, the surgery results in permanent sexual dysfunction.

2003; that plaintiff was then seen by Dr. Southhall the next day, and that, after that time, plaintiff's colorectal complaints were extensively documented. Defendant argues that, with the exception of the March 2002 complaint of rectal bleeding, none of the medical staff who testified as to their examination or treatment of plaintiff from 2000 to 2003 recalled that plaintiff ever voiced complaints of rectal pain or bleeding and that the testimony was consistent that, had plaintiff made such complaints, they would have been recorded.

{¶ 5} In order to prevail on a claim of medical malpractice or professional negligence, plaintiff must first prove: 1) the standard of care recognized by the medical community; 2) the failure of defendant to meet the requisite standard of care; and 3) a direct causal connection between the medically negligent act and the injury sustained. *Wheeler v. Wise* (1999), 133 Ohio App.3d 564; *Bruni v. Tatsumi* (1976), 46 Ohio St.2d 127. The appropriate standard of care must be proven by expert testimony. *Bruni* at 130. That expert testimony must explain what a medical professional of ordinary skill, care, and diligence in the same medical specialty would do in similar circumstances. Id.

{¶ 6} The question before the court is whether defendant's medical staff failed to timely diagnose plaintiff's condition given the information presented. Of central importance to that issue is when plaintiff began to complain of rectal pain and bleeding, symptoms that can suggest rectal cancer, and whether his complaints were made to appropriate medical personnel. On the latter issue, the following testimony and other evidence was presented.

{¶ 7} Plaintiff testified that he could accurately recall the onset of his symptoms because they occurred shortly after his release from treatment at The Ohio State University Medical Center (OSUMC) in June 2000. Plaintiff stated that the date was significant to him because he was hospitalized the day after his June 9, 2000 birthday. Indeed, on June 10, 2000, plaintiff was sent to OSUMC with complaints of chest pains. The medical records reflect that plaintiff experienced a myocardial infarction (MI). He underwent a heart catheterization and placement of a stent and was discharged on June 13, 2000. (Joint Exhibit A1, Pages 308, 314.) Plaintiff maintains that shortly after that event, he noticed a significant amount of blood in the toilet after having had a bowel movement. Plaintiff testified that he then scheduled a medical appointment and was

seen by Dr. Cloutier. According to plaintiff, Dr. Cloutier advised him not to be concerned because the bleeding was probably related to the blood-thinning medication that he was taking.

{¶ 8} Madeline Gorie, plaintiff's sister, testified that she maintained contact with plaintiff throughout his incarceration and that she recalled him complaining of rectal bleeding after his hospitalization at OSUMC. Gorie related that she told plaintiff that she had a history of hemorrhoids, that a colonoscopy had revealed the presence of a polyp, and that the polyp had subsequently been removed. Gorie further related that she advised plaintiff to seek medical attention. In addition, Gorie testified that after plaintiff's initial complaints, he continued to express concerns to her and that the symptoms he described increased in terms of extent and duration.

{¶ 9} Sergeant John Thew and Corrections Officer (CO) Richard Kepler also testified concerning their knowledge of plaintiff's complaints. Both related that they worked in an area of NCCI where plaintiff provided porter services, and that they saw plaintiff on virtually a daily basis. Thew testified that from 2000 to early 2003 plaintiff complained to him approximately three times about rectal bleeding. He stated that, on at least one occasion, he observed plaintiff in noticeable pain and sent him to the medical clinic for treatment. However, Thew testified that he was not aware of the outcome of that visit. Kepler testified that he could not recall when he heard plaintiff complaining of rectal pain or bleeding, but stated that he thought it was within the last six months before plaintiff was released on parole.[2] Kepler stated that plaintiff complained to him of hemorrhoidal pain and that, at least once, stated that his hemorrhoids were bleeding. He further testified that on several occasions plaintiff asked if he could return to his cell to change his clothing because he had bled through them.

{¶ 10} With regard to clinical medical attention it is noteworthy that as a result of the June 2000 MI, plaintiff began treatment on a "chronic care" basis at NCCI, which required that he be seen every three months for evaluation of his cardiac condition; however, other medical concerns could also be addressed at those visits. In plaintiff's case, blood pressure and vital-sign monitoring was initially conducted on a more

[2]Plaintiff's term of imprisonment expired in January 2004 and he was released on parole while hospitalized.

frequent basis. In addition to those visits, plaintiff could receive medical attention through either nurse's or doctor's "sick calls."

{¶ 11} Dr. Cloutier was the medical director of NCCI at the time that plaintiff began his chronic care visits. The medical records do not reflect that plaintiff was seen by Dr. Cloutier in either June or July of 2000, as alleged by plaintiff. Rather, the records reflect that the first time that Dr. Cloutier saw plaintiff was on October 24, 2000. Otherwise, Dr. Cloutier noted that plaintiff's blood pressure was under excellent control; there was no mention of colorectal problems.

{¶ 12} On June 21, 2001, Dr. Cloutier conducted a physical examination of plaintiff. (Joint Exhibit A5.) The evidence establishes that such examinations were regularly made available to inmates. There is no evidence to suggest that plaintiff opted to have the examination due to concerns regarding rectal pain or bleeding. The examination report does not indicate that plaintiff complained of any such concerns at that time. As part of the examination protocol, plaintiff was provided with three hemoccult stool-sample cards. The results were returned on June 13, 15, and 16, 2001, and all were negative for the presence of blood. (Joint Exhibit A1, Page 99.)

{¶ 13} Dr. Cloutier saw plaintiff seven times from October 2000 until March 21, 2002. (Joint Exhibit A1, Pages 98-102.) Dr. Cloutier insisted that, as documented in the medical records, the first time that plaintiff complained to him regarding rectal bleeding was on March 21, 2002. At that time, Dr. Cloutier prescribed Anusol suppositories. However, the medical records also reflect that medications such as Metamucil and Milk of Magnesia were ordered for plaintiff beginning in September 2000. The records do not specify why such medications were prescribed or why the medications were changed over time.

{¶ 14} Nurse Valerie Melvin and Physician's Assistant (PA) Robert Kessack examined plaintiff on November 21, 2001, and January 17, 2002, respectively. Nurse Melvin testified that plaintiff complained of a nosebleed and that, when she asked whether plaintiff had any other problems, he articulated no other complaints. PA Kessack testified that he typically asked patients whether there were any "ongoing medical problems that [they were] concerned with" and that during plaintiff's visit he did

not express any other concern. Both testified that, if such complaints had been made, their protocol required that they be documented and that they would have done so.

{¶ 15} On June 20, 2002, plaintiff was seen in the chronic care clinic by PA Nancy Williams. (Joint Exhibit A1, Page 102.) Williams testified that when she saw plaintiff on that date she would have read Dr. Cloutier's note of March 21, 2002, and would have asked whether plaintiff's complaints of rectal bleeding were still of concern to him. Williams testified that, had plaintiff told her of such problems, she would have noted the same.

{¶ 16} On February 12, 2003, plaintiff was seen during nurse's sick call, at which time he complained of hemorrhoidal pain[3] that he described as "increasing." The nurse on duty referred plaintiff to doctor's sick call, and he was seen by Dr. Southall the following day. Dr. Southall had become the medical director after Dr. Cloutier's retirement in June 2002.[4] Dr. Southall performed a digital examination of plaintiff's rectum and concluded that plaintiff was suffering from internal hemorrhoids. From February 13 to April 30, 2003, plaintiff was seen several times by Dr. Southall for hemorrhoidal pain and bleeding.

{¶ 17} On April 30, 2003, Dr. Southall ordered a consultation for plaintiff due to plaintiff's continuing complaints. (Joint Exhibit A1, Page 153.) A general surgeon from The Ohio State University Surgery Clinic conducted a physical examination of plaintiff and noted that plaintiff had an "engorged mass in [his] anus." The surgeon diagnosed the mass as hemorrhoids and recommended a soft-seat cushion and continuation of plaintiff's previously prescribed medications.

{¶ 18} After the April 30, 2003 examination, Dr. Southall continued to treat plaintiff's complaints of hemorrhoidal pain and bleeding. On November 26, 2003, Dr. Southall recommended a second consultation. (Joint Exhibit A1, Page 154.) On December 8, 2003, plaintiff was seen by a general surgeon at defendant's Corrections Medical Center. That surgeon recommended "sitz baths with cream," a future colonoscopy and hemorrhoidectomy.

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[3]There is no indication in the medical records that plaintiff had been diagnosed with hemorrhoids prior to that date.

[4]Dr. Southall died prior to trial and neither his live nor videotaped testimony was obtained for review in this case.

{¶ 19} On January 16, 2004, plaintiff was sent to Marion General Hospital with complaints of dizziness. He was diagnosed with chest pains and "obvious external hemorrhoids." (Joint Exhibit A3, Page 1050.) Plaintiff was transferred to OSUMC where he was seen by physicians from both cardiology and gastrointestinal services. Thereafter, plaintiff was diagnosed with cancer.

{¶ 20} Turning to the issue of when plaintiff's cancer should have been diagnosed, and the result of any delay in such diagnosis, both parties presented the testimony of two expert witnesses. Plaintiff presented the testimony of Michael Cooperman, M.D., who practices internal medicine, and Jeffrey Sussman, M.D., a surgical oncologist.

{¶ 21} Dr. Cooperman testified that defendant's medical staff fell below the standard of care in several respects. Specifically, Dr. Cooperman stated that the standard of care required that orders for medications, made without accompanying progress notes stating the reasons for the medication and the reasons for any subsequent changes in medication did not comply with the standard of care. Dr. Cooperman noted that medications were ordered for treatment of symptoms consistent with hemorrhoids beginning in September 2000, but that the records did not reflect that a diagnosis of hemorrhoids had yet been made. Dr. Cooperman opined that, after two orders for such medications with no relief expressed by the patient, the applicable standard of care would require that a complete history be taken and abdominal and rectal exams performed. In Dr. Cooperman's opinion, the lesion in plaintiff's rectum was low enough to have been easily detected by a digital exam at any time after 2000, and, upon discovery, should have been followed with a colonoscopy. Dr. Cooperman summarized that Drs. Cloutier and Southall failed to document or recognize the symptoms of colorectal cancer and opined that there was clearly a delay in diagnosing plaintiff's cancer.

{¶ 22} Dr. Sussman testified regarding proximate cause. He discussed the stages of cancer and the development of tumors. According to Dr. Sussman, the lesion in plaintiff's rectum was palpable as early as 2000 and became progressively larger over time. Dr. Sussman opined that if plaintiff's cancer had been identified at anytime prior to January 2003, it would have been at a less advanced stage, and could have

been removed by simple excision that would have resulted in fewer complications for plaintiff.

{¶ 23} Defendant presented the testimony of Michael Yaffe, M.D., an internal medicine practitioner, and Mark Arnold, M.D., a colorectal and general surgeon.

{¶ 24} Dr. Yaffe testified regarding the standard of care. Upon questioning by the court, Dr. Yaffe explained that rectal cancer is very similar in appearance to a swollen hemorrhoid. He noted that four physicians (Dr. Southall, the two physicians to whom plaintiff was referred for consults, and the emergency room physician at Marion General Hospital) had examined plaintiff and all had diagnosed the lesion in his rectum as hemorrhoids. Dr. Yaffe opined that plaintiff did have hemorrhoids but that the cancer was adjacent to, or hidden by, that tissue. He explained that under such circumstances, even if a colonoscopy had been ordered in March 2002 when plaintiff first complained of rectal bleeding to Dr. Cloutier, the lesion in plaintiff's rectum could have been interpreted as a "garden variety hemorrhoid" and a biopsy would not have been performed to detect if any cancer was present. Dr. Yaffe commented that approximately 90 percent of the adult population will experience hemorrhoids and/or some rectal bleeding in their lifetime. He stated that not every hemorrhoid can be biopsied. Moreover, Dr. Yaffe explained that, even if a biopsy had been performed in this case, it could have caught the hemorrhoid and missed the cancer. Dr. Yaffe offered that, in the final analysis, all physicians have to exercise clinical judgment to do what is best for a patient, that is reasonable, and that is within the standard of care at the time.

{¶ 25} With respect to the standard of care, Dr. Yaffe opined that both Drs. Cloutier and Southall met the appropriate standards in treating plaintiff.

{¶ 26} As to Dr. Cloutier, Dr. Yaffe noted that the first documented complaint of rectal bleeding was made on March 21, 2002. He opined that Dr. Cloutier met the standard of care in treating that complaint inasmuch as plaintiff was under the age of 50 at the time and had not previously voiced such a complaint to medical staff. Dr. Yaffe opined that plaintiff's symptoms at that age were more likely than not attributable to benign rectal disease for which conservative treatment, such as topical therapy, was appropriate. Dr. Yaffe further opined that the standard of care did not require that a

colonoscopy be ordered at that time, and that it was appropriate to wait and see if plaintiff responded to conservative treatment.

{¶ 27} Dr. Yaffe noted that plaintiff's next complaint of rectal bleeding was to Dr. Southall in February 2003. Dr. Yaffe opined that Dr. Southall complied with the standard of care both in attempting to get plaintiff's symptoms under control with medication and additional topical therapy, and in referring plaintiff for a consultation with a general surgeon when the rectal complaints continued. According to Dr. Yaffe, it was also within the standard of care for Dr. Southall to rely on the general surgeon's treatment plan of continuing plaintiff's prescribed medications because that surgeon would have had greater skill, training, and knowledge than Dr. Southall. He further noted that the consulting surgeon did not recommend either surgical intervention or a colonoscopy. Dr. Yaffe opined that, because Drs. Cloutier and Southall met the accepted standards of medical care in treating plaintiff, their actions did not contribute to any delay in the diagnosis of rectal carcinoma.

{¶ 28} Dr. Arnold testified with regard to proximate cause. Dr. Arnold opined that, based upon the large size of the tumor identified in plaintiff's rectum in January 2004, and its location low in his rectum adjacent to the anus, his condition was beyond excision or local therapy as early as March 2002. He explained that, even at that point, plaintiff would have required an APR and permanent colostomy, the same surgery that was ultimately performed in 2004. Therefore, Dr. Arnold opined that the actions of Drs. Cloutier and Southall were not a proximate cause of plaintiff's injuries.

{¶ 29} Upon consideration of all of the evidence, the court finds initially that the medical records are more reliable than plaintiff's testimony as to when the complaints of rectal pain and bleeding were communicated to defendant's medical staff. The testimony of Dr. Cloutier, nurse Melvin, PA Kessack, and PA Williams was competent and credible with regard to documentation of plaintiff's complaints. The court finds that, although plaintiff may have complained extensively to non-medical staff, including his sister, Sergeant Thew and CO Kepler, and other inmates, the medical documentation accurately reflects that plaintiff did not sufficiently articulate his concerns to medical personnel during chronic care or other sick call visits.

{¶ 30} The court is further persuaded that plaintiff did not sufficiently articulate the extent of his symptoms to defendant's medical staff. In light of the thorough documentation of plaintiff's cardiac care and other medical conditions throughout his incarceration, the court can find no reasonable explanation why persistent complaints of rectal pain and bleeding were not documented by defendant's medical staff, unless such complaints simply were not made. Indeed, the records demonstrate that plaintiff was seen many times for a variety of medical concerns. For example, plaintiff was seen 14 times from June to December 2000; 17 times in 2001; 15 times in 2002; and 22 times in 2003. Such evidence demonstrates that medical care was readily available and that plaintiff's medical issues were promptly addressed when presented. In short, the court finds that defendant's evidence was more credible than that offered by plaintiff on the issue of when the complaints of rectal pain and bleeding began.

{¶ 31} Having so found, the court concludes that defendant's medical staff did not fall below the standard of care in documenting plaintiff's complaints. With regard to the Metamucil and Milk of Magnesia that were dispensed from September 2000 to March 21, 2002, the court recognizes that there is no explanation why corresponding progress notes were not made. However, there was ample testimony that those medications were typical over-the-counter remedies that inmates could not freely purchase on their own; that they could be ordered for a variety of reasons, such as constipation or difficulty passing stool; and that they could be dispensed by nurses, PAs, or physicians. In addition, there was testimony that Metamucil can be prescribed for patients with heart conditions to help them avoid straining when passing stool. The court concludes that the orders for those medications fail to establish that plaintiff began his complaints of rectal bleeding in June 2000 and, therefore**,** the lack of corresponding progress notes is of no consequence to the outcome of the case.

{¶ 32} Having found that plaintiff did not articulate to defendant's medical staff his complaints of rectal pain and bleeding until 2002, the court further finds the testimony of defendant's experts to be the more credible on the question of when plaintiff's cancer should have been diagnosed. Specifically, the court is persuaded that Drs. Cloutier and Southall were not made aware that plaintiff had a condition more serious than hemorrhoids, or one that necessitated more comprehensive evaluation and treatment,

until at least March 2002. Based upon the testimony of Dr. Yaffe, the court is persuaded that plaintiff in fact had hemorrhoids, that they were contiguous to the cancer, and that even if plaintiff had been more comprehensively examined or evaluated between June 2000 and February 2003, a diagnosis of hemorrhoids, (rather than suspicions of cancer and a comprehensive followup), would not have fallen below the standard of care. Indeed, even after Dr. Southall performed a digital examination in February 2003, and began to monitor plaintiff's symptoms more closely, he and three other physicians diagnosed hemorrhoids and ordered treatment accordingly. Finally, the court is persuaded by the testimony of Dr. Arnold that even if plaintiff's cancer had been diagnosed before January 2003, the surgical outcome would have been the same.

{¶ 33} Therefore, the court concludes that plaintiff failed to meet his burden of proof under *Bruni*, supra, to demonstrate that defendant's employees were negligent or that the care and treatment they provided fell below the standard of care. Accordingly, judgment shall be rendered in favor of defendant.

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DEPARTMENT OF REHABILITATION AND CORRECTION

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Case No. 2005-01421

Judge J. Craig Wright

JUDGMENT ENTRY

This case was tried to the court on the issue of liability. The court has considered the evidence and, for the reasons set forth in the decision filed concurrently herewith, judgment is rendered in favor of defendant. Court costs are assessed against plaintiff. The clerk shall serve upon all parties notice of this judgment and its date of entry upon the journal.

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J. CRAIG WRIGHT
Judge

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LH/cmd/Filed January 14, 2009/To S.C. reporter February 10, 2009