IN THE COURT OF COMMON PLEAS

GUYABOGA COUNTY, OHIO

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Doc. 341

REBECCA WILSON, ADMINISTRATRIX OF THE ESTATE OF WILLIE WILHOITE, DECEASED,
Plaintiff,
vs.
AMBASSADOR NURSING CENTER, INC. and JON M. RAINEP, M.D.
Defendants.

CASE NO, 162481

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Deposition of ROBERT E. NORMAN, M.D., a Witness herein, called by the Defendants for cross-examination pursuant to the Rules of Civil Procedure, taken before me, the undersigned, Laura E, Pavlick, an RPR and Notary Public in and for the State of Ohio, at the offices of Robert E, Norman, 777 West Market Street, Akron, Ohio, on Wednesday, tho 29th day of November, 1989, at 2:10 o'clock p.m.

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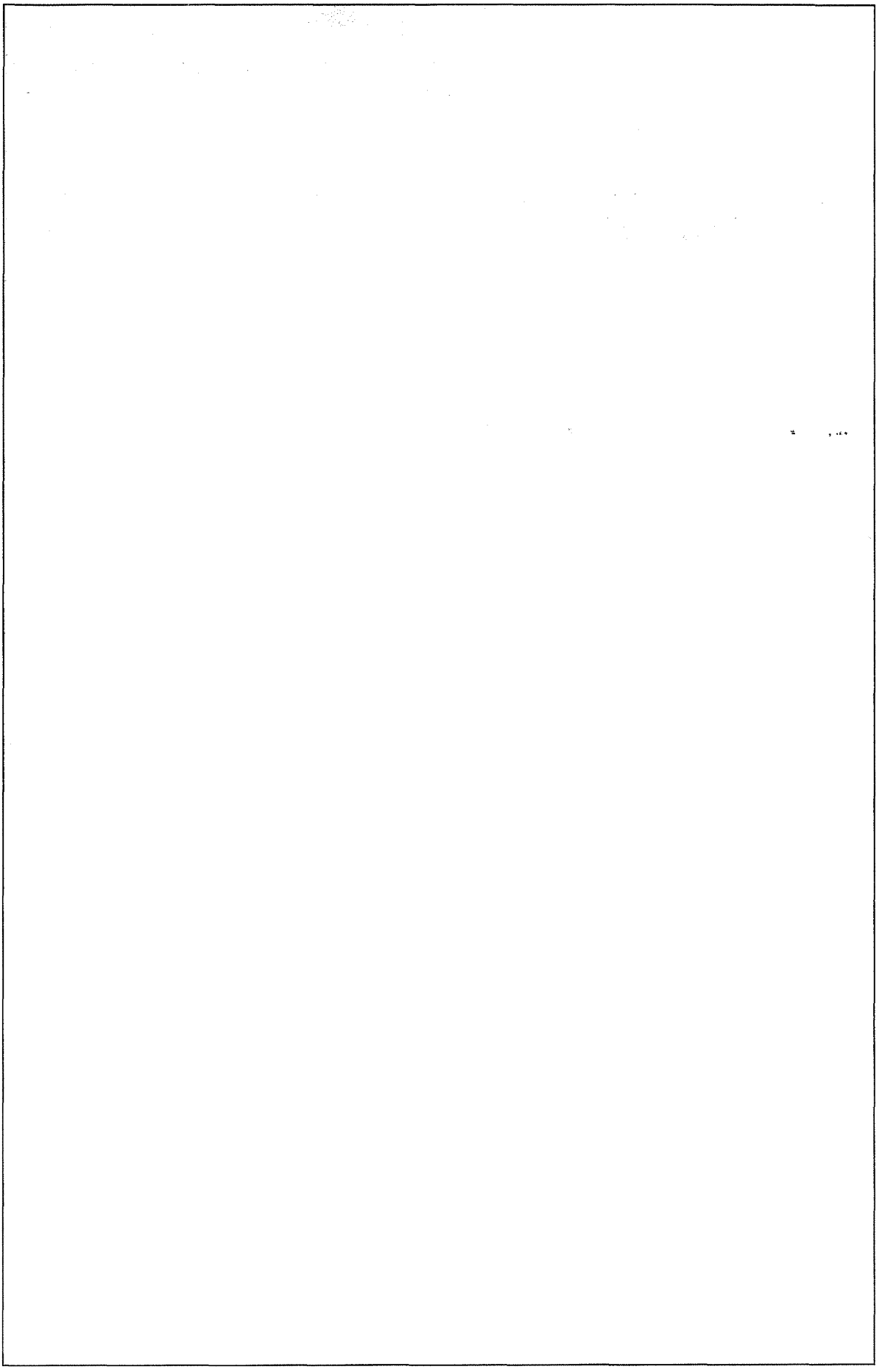

APPEARANCES:

On Behalf of the Plaintiff:

By: Charles M. Delbaum, Attorney at Law
Suite 1620 Standard Building
1370 Ontario Street
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On Behalf of the Defendant Dr. Rainey:

Messrs. Jacobson, Maynard, Tuschman & Kalur, Co., L.P.A.

By: Robert C. Seibel, Attorney at Law
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On Behalf of the Defendant Ambassador Nursing Center, Inc.:

By: Neil E, Roberts, Attorney at Law
1806 Illuminating Building
55 Public Square
Cleveland, Ohio 44113

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I-N-D-E-X

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ROBERT E. NORMAN, M.D.

of lawful age, a Witness herein, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. SEIBEL:

Q. Doctor, we were introduced briefly before, My name is Bob Seibel and I represent Dr, Rainey in the case in which you have been identified as an expert witness, Just for the record, 5 am going to hand you a check for -- in the amount: of $500.

A. Okay.

Q. Which we have been told is your fee for your deposition today; is that correct?

A. Yes.

Q. Okay, Doctor, would you state your name for the record, please.

A. Robert Elwood Norman -- I kind of use junior sometimes -- Jr.

Q. Rave you ever gone by any other name?

A. No, other than Bob,

Q. That's fine, What is your residence address?

A. 371 Merriman, M-E-R-R-I-M-A-N, Road, Akron.

Q. And what is your business address?

A. 777 West Market, Akron,
Q. And that's where we are today?
A. Right,
Q. How long have you been at this business address:,
A, Since duly of 1978.
Q. Did you maintain an office some other place before then?
A. I was in the same building for a month, same address, where the hearing people are now,
Q. Is that where youx practice started?
A. T had started for a month in the office next door until these people moved out, They had an office building built for them, It was the same business address,
Q. Have you practiced at any other location other than this address?
A. No. Well, *yes*,
Q. Where was that?
A. In Stow, Ohio, I can't tall you the name, the address number, but it was on 59, Kent Road, I -- a guy was retiring and I kind of helped with his patients for about eight months,
Q. Who was that doctor?
A. Dr. Vaughn Smith, V-A-U-G-H-N.

Q. Is he still alive?

A. Yes, yes.

Q. Do you have a CV, Doctor?

A. Yeah, I do, as a matter of fact, Geez, I wonder where it is? Hey, Janet --

MR. SEIBEL: We can go off the record for a minute,

(Discussion had off the record.)

BY MR. SEIBEL:

Q. Doctor, you have handed me a copy of your curriculum vitae, Is this up to date?

A. The only other thing that would be probably pertinent to that, let's see, since then I have joined two organizations; one is the American Rome Care Physicians and the other one is the American Medical Directors Association. And I don't think I put those on there, if I am not mistaken,

Q. Can I keep this copy?

A. Can I make you a copy of that: one?

Q. Sure, At the end of your deposition if you just give us a copy that would be fine,

Doctor, have you ever been convicted of a crime?

A, No.

Q. Would you -- well, what is your occupation?

A, Physician.
Q. Are you a medical doctor?
A. M.D., physician.
Q. Would you describe your practice, please?
A. It's principally geriatrics. Probably 90, 95 percent of it is geriatrics, and that: incorporates an in-office practice plus a nursing home practice, I have a couple nursing homes in the area. And I do -- I don't know if that comes under the practice. I am on the, I do teaching, geriatrics teaching at Akron City Hospital, I am in charge, currently in charge right now of their program, teaching program,
Q. What constitutes the other five to ten percent of your practice that is not geriatrics?
A, Same of it is HMOs. I joined some of them because I thought that Medi-Care was going to go into HMO, Government was pushing it, so I joined some, And they're almost all 30, 40 year old people.
And then I have some patients who family members of -- I have an 80 year old that says, "Can you see my son or can you see my granddaughter?" If I have the time I never, you know, I always take them on. Plus when I started my practice in '78, for the first couple years I took anyone that walked in the door, crawled In, got them out of the parking lot, you know, You are

hungry to see patients, '80 is when I switched to geriatrics,

Q. Are you licensed in the State of Ohio?

A, Yes.

Q. When were you licensed?

A. Um-m, August of '76.

Q. Are you licensed in any other states?

A. No.

Q. Rave you attempted to become licensed in any other state?

A. No.

Q. Mas your License to practice medicine in Ohio ever been revoked, suspended or restricted in any way?

A. No.

Q. Would you tell me where you went to undergraduate school, please?

A. West Virginia University,

Q. And when did you graduate from there?

A. 1971.

Q. Did you -- what degree did you obtain?

A, AB, biology.

Q. An Associate's Degree?

A. Yeah. BA.

Q. Or Bachelor's Degree?

A. Bachelor's Degree. Excuse me, Bachelor's Degree, It's hard to remember those things sometimes,

Q. When bid you start medical school?

A. August of '71.

Q. So immediately following your graduation from college you started medical school?

A. Yes.

Q. And where did you go to medical school?

A. West Virginia University.

Q. And when did you graduate from medical school?

A. May of '75.

Q. Did you go to a residency program from there?

A. Yes, at: Akron City Hospital three years, got out in 1978, And it was a medicine, internal medicine residency,

Q. Were you at any time the senior resident during that residency program?

A, I was the chief resident from '77 to '78. As chief of tho house staff rather: than chief of an individual service. It's more of a popularity than academic positian'

Q. You are elected by your peers?

A. Yes.

Q. Are you Board certified?
A. No.
Q. Have you ever attempted to become Board certified?
A. Halfheartedly.
Q. What do you mean by that?
A. Well, I don't like the Boards and I had some bad experiences in medical school that made me anti-academus, and you know, I really went out of my way. I didn't study for them, I took them basically because we were told we were supposed to, I have -- maybe might have done something different if I wasn't -- X was very much more radical, I have mellowed as of age. It was more of an anti-status statement.
Q. You did take them, though, at one point?
A. Yes, when I got out of my residency, yeah, I guess when I got out of my residency.
Q. That would have been in '78?
A, Yes.
Q. Did you take -- do the -- I take it -- strike that. I assume that these are the internal medicine boards we are talking about?
A. Yes, I am sorry. Internal medicine,
Q. Did you, does that test comprise both an oral and written component?

A. Just written,

Q. Just written, And I understand that you failed the written portion of that test?

A. Well, that's all it was, it was written,

Q. Okay, And you failed that test, though?

A. Yes.

Q. I believe you mentioned before you had privileges at some hospitals, What hospitals do you have privileges at?

A. Right now Akron City Hospital,

Q. Rave you ever had privileges at any other hospital?

A. Yes, I had them at -- emergency room privileges at Wooster Hospital in Wooster, Ohio, I worked there several years moonlighting, I had privileges at Barberton Citizens Hospital €or a year or two, but then it got too far to go. It's on the other side of town.

I had privileges for about a year at St. Thomas, but I dropped out of that because it was just too hard. I thought one hospital was the easiest, just stick with one spot,

Q. Were you employed by the emergency room group that serviced the hospital in Wooster?

A. Yeah.

Q. Do you remember the name of that group?
A, The name waa Jack Martin, it was out of Cleveland, I can't -- Emergency Medical Specialists or something like that, Et was Jack Martin who had the group, and they were on Chagrin Falls Boulevard, but beyond that point -- it was about four years ago that I quit doing khat, and I remember Jack vividly, but beyond that I am not sure.
Q. And what years did you have privileges at Barberton Citizens Hospital?
A. I am not really sure. Maybe -- it's been a long time ago, I would only be guessing. I would say maybe six OK seven years ago for a couple years. And it was approximately the same time as when I was at St. Thomas, I thought that I needed more hospitals hence I would get more work, and that theory didn't pan out. Got more work but I didn't have any time,
Q. So you are saying that you voluntarily relinquished your privileges at Barberton Citizens Hospital and St. Thomas?
A. Well, yeah, kind of, Barberton I had a run-in with the people over there. I thought I was reverse discrimination,
Q. Tell me about that,
A, They, I -- everyone wno gets on the staff

there would get -- be given a month in the emergency room, not, you know, to take people who came in to the emergency room who didn't have a physician, And that was just routine, I didn't get my month and I complained, and they said, well, it was a couple people on the staff that felt that being an American, and that's basically a non-American hospital, you would not get -- you would get too many patients, That's what I was told, True or not remains to Be seen,

And so I hung it out for awhile, and the mora I hung it out the more irritated I gat, so I told them to stick it,

Q. You felt you were being discriminated against because you were --

A, American.

Q. -- native American, okay, And the foreign doctors were receiving preferential treatment?

A, I thought so. Whether it was true or not, it was my -- at that time, like I said, I was looking for more work and I felt I was not given an opportunity to get it,

Q. Did you have the same sort of run-in with the people at St. Thomas?

A. Huh-uh, it was a time factor, I started getting busier et City, because I got more referrals, and

it just became apparent that it was no way I had time, and I didn't like St. Thomas as well as I liked City,

Q. Have you ever been denied staff privileges at any hospital?

A. Not that I recall, no,

Q. Have your staff privileges at any hospital ever been revoked or restricted in any way?

A. You know, I might have, you know, The more I think about it, it was awhile back, but I think at St. Thomas I know I was quitting there, but it seems to me, I don't know if I quit before they revoked my privileges for not going to the annual staff meeting or not, I am not sure, I kind of let it slide, It may have come before the other, you know, they may have said, you didn't: go to the meeting, Of course I wasn't going to the meeting because I was going to hang it up, I can't remember, to be honest with you, but I think it's conceivable that that could have been revoked far not going to a staff meeting. Kind of a gray area, I can't quite remember.

Q. Do you think it more likely happened that you were revoked before you quit?

A* I knew I was going to quit irregardless, and to me, as I remember it, it seems like, that it was a possibility that -- but I know I didn't go to the

meeting, but T had already planned to leave at that point in time. Because, you know, you have to go -- at City you have to go to one meeting a year out of two, I think the same was at St. Thomas, but I already made my decision to cease my privileges there.

Q. Have you attended any other post high school education other than your undergraduate degree and medical degree at West Virginia University?

A. You mean not meetings or courses?

Q. Formal education.

A. No.

Q. When did you graduate from high school?

A* 1967.

Q. And where did you go to high school?

A. Tridelphia High School in Wheeling, West Virginia.

Q. - . Do you belong to any professional organizations or societies?

A. Yes.

Q. And which ones?

a. American Society of Internal Medicine, Ohio State Medical Association, Summit County Medical Association, American Geriatric Society, American -- American Home Care Physicians, American Medical Directors Association. I think that's -- I think that's it.

Q. Those are your current memberships?
A. Yeah.
Q. Any, any memberships in any organizations in the past that you are no longer currently a member of?
A. I was in the Southern Medical Association. That's one I had to think about, I think I just quit them, I debated on rejoining them, Basically an association for southern physicians, Really don't have too many members up north, I Joined it because they had -- I liked their journal; but as I got more and more involved with geriatrics their journal has almost none in it, so I have concentrated on others, and if I am not mistaken I am now out of it,
Q. Tell me what the American Home Physicians Association does.
A. It just was started about a year, year and a half ago maximum, The gist of it is there are physicians who do home visits, house calls, kind of an organization to help each other on how you *bo* it. It was, there is only one meeting that I am aware of that they have ever even had, and that was up in Boston, I attended it at the end of April.
Q. What about the other, American Medical Directors Association?
A, Yeah, that's for the medical directors of

nursing homes. That's been around much longer than I ever have. I joined that about six or eight months ago. I didn't even know they existed, And I have been the medical director of a couple of nursing homes, I thought that might be a nice source of information on how to do what to do the job,

Q. What nursing homes are you affiliated with?

A. Well, I am affiliated with most of them, but I have had the -- mostly right now where I concentrate my patients is Rockynol, Valley View, and Hillhaven.

Q. Those are all local in the Akron area?

A. Yeah, they're! all fairly close to here.

Q. Any others that you have patients in?

A4 Right now that: I am following, no, I have got a couple that are in nursing homes that T don't follow, but they, the patients, I have a couple in Stow-Glenn, but I told them that's; 35 minutes, 40 minutes from here, *it's* almost up to Kent. Patient's family brings, physically brings the person here so I don't have to go out there, that was the deal. But a don't see them there.

Q. Okay.

A. *And* there is one in Pebble Creek the same, under the same circumstances, that they bring them here as needed rather than going there, because they have no

major medical problems other than just can't care for themselves,

Q. Do you participate in any organization that's referred to as en ombudsman, a nursing home ombudsman association?

A. Well, I am not aware that they're open to participation, I certainly have dealt a lot with them,

a. Tell me what you know about that oxganization.

A. Well, the four county ombudsman that I -- used to be here that we -- used to be a separate organization, now has been assumed by the area Agency on Aging just in the last year, Becky Snyder who used to run it, we were on the phone to each other all the time; because I was often used as a source for, what do you think about this, what do you think about that? Then when I Rad a problem I had someone I could call up and say, you know, do you think this is the way it's supposed to be?

And Debbie Allen, who is one of the people, working for her, was someone that I had worked with a lot, too, and her husband, So I got involved in that because I, because of these people that I knew, plus of all the nursing home work, and knowing Becky, who had run the operation.

Now since it's been incorporated into the area Agency on Aging, I mean, I know the people down there because I do stuff with them, X an not with them with them, so to speak,

Q. What counties does that encompass?

A. Portage, Medina, Portage -- let's see. It's Portage, Medina, Summit: and I think Wayne.

Q. Okay, Not Cuyakoga County?

A. No, doesn't go up that far. I don't think it hits Stark either.

Q. Is there a similar organization you are familiar with in Cuyahoga County?

A. Am I familiar with it? No, I just, I make an assumption that there was one, but familiarity with it, no,

Q. Okay. Is this a county-controlled agency that you ate familiar with?

A. It had been, it had been a functioning unit, as Ear as I knew, by itself with some screening from Medi-Care/Medicaid somehow coming in through Title 20 or one of those, That's haw I understood it to be, Now it's a state agency,

Q. Is --

A, The area Agency on Aging.

Q. Do you know what the role of th s agency is?

A. Um-m, basically to intercede in disputes between nursing home families, patients and dealing with the nursing home administration, nursing staff, et cetera. Recourse that they have when they have problems, they need help with something. And E think it worked the other way, too, If I have a problem with the families or the nursing home, I can go through them, So I see it as a two-way street with that.

Q. Has to do with the quality of care rendered at the nursing home?

A. To a certain extent, yeah, Sometimes I think they get hung up on specific issues, but yeah, basic quality of care, patient's rights, are their rights being violated, et cetera, yes.

Q. And is there a Board or something that: is involved in this agency?

A, Not that I am aware of. It is now because the area Agency on Aging has a Board that. governs them, the local. agency, Plus the state, the state area, the State Agency on Aging, so there is a Board now, E don't know about previously. I wasn't aware of one. There could have been.

Q. Okay. Do you know if Mr. Delbaum wad involved in the Board down here?

A. I would say probably not, but I don't know

for sure. I know most of the people on the Board because I have dealt with them, but I don't know everybody on the Board. So I would say I have no way of knowing for sure.

Q. Would you describe your employment since you entered the private practice of medicine?

A. How do *you* mean employment? You mean who I work for?

Q. Are you self-employed?

A. Yes.

Q. Have you been, other than the brief period we talked about with the physician in Stow who is retiring, but apart from that, have you basically been a solo physician?

A. Except for the nursing home and -- I mean the emergency room care that I had alluded to --

Q. Okay,

A. -- where I worked for somebody and was sent: mostly to Wooster, but you know, you were sort of on call, I went *to* a couple other places, but basically I worked out of Wooster. So I worked for that company,

Q. Would that basically describe your employment up to this point as a physician?

A. Let me think a second, I have got grants far things, but I guess that's not employment.

Q. Well, such as?

A. Well, I have gotten a grant, two grants from -- one is from Akron City Hospital Foundation on a research project for a case management. in geriatric assessments, which I am the principal investigator. I get paid from, you know, I got a check from the hospital for that.

I got a grant that I am involved with, or I am the principal push-over, My portion of it is to put up and run the geriatric teaching program at City Hospital. And I get moneys from a grant that someone else put in for for an overall variety of programs that might happen to be that, so I get money for that,

Q. Are you employed by the hospital independent of that grant?

A. Well, I think I am. I am an independent, 3 don't think, I think I am a -- I don't think I work for the hospital. The hospital pays me, but I think the grant money comes in to the Department of Medicine. It's sent to the hospital and usually the grants run and 3 gat a check from the hospital, but I don't -- I think my contract says I am not employed by them, They're just the ones who disburse the funds.

Q. Who do you teach at the hospital?

A. Medical residents, 3 guess, and interns, I can lump them all as residents, but interns or residents,

Q. Have you ever written any articles?
A. And been published? No.
Q. What about subscriptions to medical journals: do you subscribe to any?
A. Oh, I have a lot of them, Of course the one you're a member of their organization you get, you get a journal for that, So the American -- I get the journal of the American Geriatric Society because I am in that: society, I get Geriatrics, I get Geriatric Consultant, New England Journal of Medicine, Consultant, Patients Care, Medical Clinics of North America, Geriatric Clinics of North America, I don't think I have the Northamerican geriatric Clinics.

Senior Patient. I know there is at least: six or seven that I get €or free, but: you know, they select random physicians and yau sign a little card and you get them for -- like family practice, Journal of Family Practice, I don't pay *for* that, that come8 because I sign a little thing, I get six or eight of them like that.

Q. *80* a lot of those journals have articles that relate to the care of the aged, decubitus ulcer, cere and management of Alzheimer's disease, nursing home care, that type of thing?
A, Yes.

Q. Were you ever in the Military?

A. No.

Q. Other than the position that we talked about at Akron City Hospital teaching residents about geriatrics, have you had any other academic ox teaching positions?

A. I am an instructor in medicine at the Northeastern Ohio University Collage of Medicine.

Q. Are you actively involved in that program?

A, Yes. Not as much in -- my faculty range is in the Department of Medicine, but I am also in the Geriatrics Department, which is part of community medicine. I do mast of my work through the geriatric committees or teaching,

Q. Have you taught a course there this last semestet?

A. Course there? Ma,

Q. Okay. When was the last time you taught a course there?

A. Let's see. Well, thooretically, you know, I have an elective, I have two electives that I am involved with; ane of them is through this grant that I have, and it's -- we rotate residents and medical students,

It's a -- what word? They don't: have to take it, it's an elective, and I am on the books for

that, No one has signed up for it, it was just approved last: year, E don't think we had any medical students yet come through it.

That's what I have been doing, 1 haven't formally went out and taught classes, generally what I have done, either what they call tutorial sessions, I used to do those when I had more time, where you give up a a few hours a week and sit down with the residents, I mean the medical students so they can ask you stupid questions that they're afraid to ask anyone else,

I did that for about four or five years, and then as the Geriatrics Department got bigger I pretty much have been in electives with that, Then they rotated, one year I think I had three people rotate through here. We may have about -- well, haven't had any for maybe two, three years now.

Q. And no one has taken the course that you were assigned to teach?

A. Not -- well, it just started, but no, not yet.

Q. All right, Have you ever conducted any research into the cave of the aged?

A. Well, the research grant that I have now for case management, yes.

Q. What does that: involve?

A. Theory being that Medi-Care doesn't pay for anything preventive, per se. A little bit here and there, but basically it's not preventive medicine, it's an acute incident type, we will take care of it as you get your pneumonia, but we won't help you prevent your pneumonia,

What I do is do geriatric assessments where I go out and evaluate them with a geriatric nurse, social worker, come to some conclusion what their needs may be, and if they're in our program we go ahead and take care of those needs,

If it's a physician that referred them then we write it out and send it back to them. What we do is -- the grant part of that is you normally then just leave the patient alone, they're not your patient, they're someone else's or whatever, The case management part is every month if I say, I think they need physical therapy, you call back in two weeks, or say, okay, are you getting your physical therapy? Well, no. Why aren't you? Well, Medi-Care wouldn't pay for it. Well, then my grant pays for it to prove that if you pay a few bucks now, you save a whole lot later. That's what the gist of the grant is, that's the way it's been going on for about a year now.

Q. So you are trying to identify issues related

to care of the aged which will --

A. Keep them out of the hospital.

Q. -- pertain to prevention?

A. Yeah.

Q. Have you ever conducted any research in the area of Alzheimer's disease?

A. Well, that kind of blends in with this, but Alzheimer's *pew se*, no.

Q. Have you ever conducted any research into the issues surrounding decubitus ulcer care?

A. Not formal research, but I have done my own work on trying, working with residents when they come in aver like at Hillhaven, family practice residents from St. Thomas rotate through my office, I don't think I mentioned that, maybe it didn't come up, And part of the program I do with them is since they are right across the street from Hillhaven, with the nursing home I am involved with, mostly they come over there, we make rounds and I go over what I have used in the past,

And I often work with the nursing staff, yaw know, when they used to have decubiti, they almost never have them, they have a decubitus team, it doesn't came up. I have done my own work, not published, used it for teaching purposes with the residents on what they could use the best, I have tried thio, this doesn't

work, or yes, this works, so here's what you ought to use. Nothing more than antidotal,

Q. Dr. Norman, is at least three quarters of your professional time spent in the active clinical practice of medicine or teaching at an accredited medical school?

A. Yes.

Q. Have you ever testified as an expert witness before?

A. No. I have testified before, but I don't think I was considered an expert witness. I do a lot of work in Probate Court with guardianships, I get called in for opinion, I don't think that's called an expert witness.

Q. Have yau ever given a deposition before in a case?

A. Yes.

Q. Tell. me the context of that.

A. I had a patient that had fallen a couple three or four years, worked at Akron City Hospital, and he thought he got an on-the-job infection, almost lost his arm. They had to fillet his arm open and dig out the tissue, which he wasn't real keen about, but he literally could have died from it,

About two or three years later he sued the

hospital as a Worker's Compensation claim, Since I was his physician I had to give a deposition on whether I thought it was hospital acquired or not, As far as I can think, that's -- memory serves me correct, I think that's the only time,

Q. So you have never testified in a medical malpractice case before?

A, No.

Q. Are you a member of any organization that reviews medical malpractice cases?

A. No.

Q. Well, what is your arrangement --

A* Well, I take that back. We do that to a certain extent at Summit County Medical Association. I am on the council, which is the governing body, and people who bring it to us who have been sued, we have two or three physicians who asked us for help, and we review it in that respect, yes, but not otherwise,

Q. What is your arrangement for providing expert witness testimony in this case? I know we had to pay you $500 for your deposition today, but; what other arrangements have you made with Mr. Delbaum or the Plaintiffs?

A. I don't think anything else.

Q. Have *you* charged him far reviewing the

records and rendering your report?

A. I charged him, yes, for reviewing the records,

Q. What did you charge him?

A. $100 an hour.

Q. Have you ever been sued for malpractice?

A. Once, I was taken off the case in about five minutes, but I guess it would count. I never really got formally handed something that says, "You are being sued." I was mentioned in one and it was my patient called up and said, I am sorry, you axe not supposed to be in this, I didn't mean to name you. And she still sees me, it wae back six years ago. I don't know if that counts or not, but --

Q. That*@been the only time?

A* Yes.

Q. Do you have a file in this matter?

A. I have these records that -- these.

Q. What does your file consist of?

A. I assume the chart: at: Brentwood Hospital. Th s is basically the whole chart: from Brentwood, This is the first admission to Ambassador Nursing Home, all of their records, the records from Huron Woad Hospital which followed, then the Ambassador Nursing Home second visit. And then the -- excuse me, University Hospital,

deposition of Dr. Rainey, and then my notes on the subject.

Q. Okay, Can I take a look at your notes?

A, Sure. I will show you where they are. I got lots of other notes in there, by the way, other things,

Q. I don't want to look at those, We will look at his nates in awhile,

Doctor, I have been furnished *two* reports, two letter reports in this case that you have written; one dated November 22nd, 1988 and the second one dated February 20th, 1989. Rave you issued any other reports in this case other than those two?

A, Not that I am aware of. No more letters,

Q. Okay, What were the circumstances that led to your issuing the February '89 report?

A. Is that the first ones?

Q. That's the second one,

A. The second one. I don't happen to have a copy of that at the moment.

Q. Would *you* like that?

MR. DELBAUM: Would you like to see one?

THE WITNESS: Yeah, I would love to.

(Handing document to Doctor,)

THE WITNESS: Okay. Yeah, I wrote my

original letter, Mr. Delbaum felt that, you know, like I said, I have never done this before, so he said I wasn't real clear in what I meant, I knew what I meant and I told him over the phone what I meant. He says, could you go back and say what you mean? You didn't say it right, as well the first time, So this was a response to khat,

BY MR. SEIBEL:

Q. Tell me what Mr. Delbaum said to you and what you said to him that led to the production of this February of '89 letter,

A. Basically probably the part which you have outlined, because I don't think I made a comment to tha effect that -- how much that was linked to her eventual demise, which I thought it actually was, that the decubiti were clearly linked to her death, and I don't think I was clear to that in the first letter,

And I think in the first letter I didn't mention very much about the physician, Dr. Rainey, I was thinking more on the nursing home, because that's what I had in my mind, That was my job, more or Less, to discuss the nursing home part of it,

And he asked me, I think he said, do you think there is physician involvement? Then I went back, because I was dealing mostly with what -- with the nursing home originally, I remember correctly.

Q. Your initial consultation -- well, let me strike that. Let me ask it a different way,

Do you recall when you were initially contacted by Mr. Delbaum about this case?

A. I know it took forever to do it, but I don t know.

Q. Sometime before November of 1988, correct? Because that's when your first report is.

A. 3 think it took me four months, three or four months to review everything, so I would say it was late summer, maybe September.

Q. And your initial evaluation was directed to the nursing home primarily?

A. Right, I thought -- I don't know what I thought for sure, but I think I was, I had in my mind that that's all I was supposed to look at, basically.

Q. Okay.

A, Whether right or wrong, 5 thfnk that's what I thought.

Q. And it wasn't: until you produced your November, 1988 letter that Mr. Delbaum informed you that you were also supposed to be critical of the doctor involved?

A. I don't know if I was supposed to be, I think he asked me for the opinion on the subject and 3

had an opinion on the subject.

Q. Okay, Why don't you give me that letter back.

A. Certainly,

Q. Before today have you ever met with Mr. Delbaum in person?

A. No.

Q. only over the phone?

A. Yes, only over the phone.

Q. About how many telephone calls did you have prior to the November, 1988 letter?

A. I think three of them were to remind me that I was going to do it, He called me once and asked me would I be interested, and I hemmed and hawed a little bit about that, I said, okay, let me look over it, And I think about -- he called me maybe two or three times after that. I wasn't real fast in getting everything done, it's a very busy practice, And I think that he, you know, basically maybe three calls, gee, you got this done yet? Are you getting anywhere with it? And then probably one more on the subject of would I be a little bit more specific, you may be a little bit too vague,

And then I don't think I heard from him again until, well, if up to November of '88, that would have been the last I had talked to him until we set thi

up.

Q. Did Mr. Delbaum ever tell you how he got your name?

A, Yes.

Q. Wow was that?

A. Through Debbie Allen, who was an ombudsman here in town that I knew,

Q. Is Ms. Allen a physician?

A. No. I am not sure what her background is. I know it wasn't a physician, She had been an ombudsman here,

Q. And she's now involved in the agency apparently that oversees that?

A. She's up in Cleveland somewhere, that's all I know,

Q. Okay, When was the last time you talked to her?

A. Three years ago, four years ago maybe. Whenever she left town here,

Q. Sa you were familiar with Ms. Allen based upon her work here in Summit County with the ombudsman?

A. Two ways, I was on a Board of Directors for a Major Robert Wood Johnson Foundation Grant for keeping elderly people from falling through the crack, sa to speak, and trying to find people who were in need of

agency services who were forgotten people,

Her husband was the Executive Director of that, John Allen, her husband at the time. I knew John because I worked with him, We met and I was the only physician on the Board, so all the medical stuff went to me to help make decisions. So I knew John very well, that's how I met his wife. And then I started knowing her through the Ombudsman, as *you* know. If there would be problems she would call me up and say, "What do you think about this?" sometimes something else, or problems with my families that I maybe wasn't aware about, So that's how I kind of got to know her.

Q. What authority does the Ombudsman have or did the Ombudsman have when it existed?

A. Well, they had the -- they had the authority to at least evaluate and investigate things, And as best as I understood it, if they thought there was a problem they had no penalty thing that they could do, they would turn it over to the State Attorney General,

I know it happened in one case because it was one of my patients that I had to meet with the Attorney General guy that they sent up here, And I think I thought basically they were -- found the information, then if they thought it was something they turned it over. That's how I understood it,

Q. So one of the patients the Ombudsman investigated and thought there was a problem, which then prompted an investigation by the Attorney General of you?

A. Yeah. Clarify, not of me, of the nursing home, They said they improperly put on a restraint, Basically what happened was the person got restrained fox more than twelve hours without my order, and that's a against the rules. And the family challenged that and they made a big case out of it, I thought it war grossly overplayed, but they didn't get an order from me for it. They have the right to do that for twelve hours.

Q. Did they sue the nursing hone?

A. It was dropped after the investigation. The patient remained at the nursing home. Like I said, I think everyone just was stomping around, because the family kept them there.

Q. By the way, on my way into your office this morning on Market Street I passed a Manor Care Nursing Home. Do you do any work there?

A. No. I have had patients there, but no, I have limited my, limited my care.

Q. Dr. Norman, what have you -- whet have you reviewed in this case to render your opinions?

A. I reviewed the records that I previously mentioned, the two hospitalizations. Well, I guess there

is three hospitalizations, and the two stays at the nursing home.

Q. What --

A, I really paid minimal attention to Dr. Rainey's -- I didn't really have time to read through what he; had,

Q. Did you read his deposition?

A, I just kind of skimmed through it. If you asked me what was in it I couldn't even tell you.

Q. That didn't matter to you?

A, Well, not really, because I had felt that, you know, that's really what tells it, (indicating). Plus, you know, he ha8 his -- he had his reasons why he thought what he did, and I didn't think that was important for what I thought happened,

MR. DELBAUM: I would like the record to show that the witness was pointing to the records when he said, "That's really what tells it".

MR. SEIBEL: I will stipulate to that.

MR. DELBAUM: Okay.

BY MR. SEIBEL:

Q. Well, what are the facts of the case as you know them from your review of the records?

A, Okay, How I see it, there was a couple main problems. The patient was --

Q. I am not asking for your criticisms, I am asking wheat --

A. What do I see as the main problems?

Q. No, I am not asking you what you see as the main problems. What I am asking you, what aro the facts of this case?

A. Okay. Let me see if I can do that without any opinions, Okay. The fact of the case as I see it is a woman who is in fairly poor health came from Brentwood Hospital to Ambassador Nursing Home on April 9th, 1987.

Q. By the way, this isn't a memory test. You can look to the records if you want to.

a, When I need it I will grab it.

Q. Okay.

A. That she was mildly malnourished, she had flexion contractures, so she was drawn up, she was demented, minimally verbal, very poor aptitude and had a feeding tube in to sustain her.

While she was at the nursing home the first time she came in with a couple decubiti, There was a couple present when she was there, first admitted, And that was basically one on her shoulder or elbow that healed, and a couple on her feet that pretty much stayed there.

During the time she was admitted, from one

end of the time to the time she was discharged, she developed worsening of the already present decubiti except the one that had healed. And then one seemed to appear out of nowhere on her left buttock that was never described really at the nursing home.

During the period of time she was there her health did decline. She had a fever on 4/15/87, and basically it stayed there until she was admitted to the hospital on the 28th. Was two days it was 99, but basically was always a fever present. The 21st of May it was decided that her health was definitely worsening, chest X-ray said bilateral pneumonia to account for her fever.

She was started on Zinacef, which is broad spectrum antibiotic, certainly a good choice. And she didn't really do too well, she still stayed pretty crummy, and it was felt that she initially had urosepsis and was transferred then to Huron Road Hospital.

When she was admitted there she had much larger decubiti. A few days afterwards when they were described they were not described by size, by, you know, actual centimeter, by centimeter when she was first admitted there. It was not until a few days later that they were actually described by size. They were significantly bigger, two to three times bigger than the

description, the last description that was available at the nursing home, plus they were infected and very necrotic,

And then second there was a new one that -- apparently that was not ever described at the nursing home, Fairly large one, at least ten centimeters by one description, and ten by 15 almost by another one, but it was big, Dr. Rainey said it was large, on her left buttock that was not previously identified, It was also infected and necrotic.

She received debridement there by the doctor. His notes indicate "Wounds cleaned up, given antibiotics." For all intents and purposes they were happy with the improvement she herd. They increased her tube feedings, gave her a little bit more nutrition, Had a dietitian consult, said, you need more food, give hex more food and sent her out in I would say fairly decent shape. Although I don't think the decubiti were perfectly clean when she left there,

Cot back to the nursing home, and at no surprise she just continued to dwindle. I mean, she just really had a13 the cards stacked against her, Decubiti continued to get bigger, stayed necrotic, periods of time they were infected but always were described as necrotic. And eventually someone said, gee, I think her knee

prosthesis is showing, kind of hanging out.

She then was going to be sent to one hospital, I forget which one it was, changed their mind and went to University instead, at which time she had an amputation to try to salvage her existence; and even considered taking it even higher. I think it was an above-the-knee amputation, talked about disarticulating the whole leg.

Whether she would have survived if they would have done that remains to be seen. Certainly she might be able to. At that time she went on and, you know, ceased to breathe, and it was felt that -- she had an autopsy and she had infected decubiti. They did prove that she had Alzheimer's from the autopsy. She had some congestion in various organs at that time, but they clearly, I think the cause of death was infection.

Q. What is Alzheimer's disease?

A. Alzheimer's disease is a degenerative process of the brain generally seen in plus 60 year old people. It can be an earlier onset. Its hallmark on pathology, what is called neurofibrillary tangles, an amplified deposition which is called senile plaques, which is how they make the diagnosis. That's the hallmark. Old people have those, there is significantly more of them, that's how you make the diagnosis of

Alzheimer's disease,

It's a degenerative disease, it's incurable progressing over a maybe 15 to 20 year course. Normally is a supermalignant, kind of a slow process, doesn't speed up real quick, and it's a lousy disease.

Q. Eventually claims the life of its victim?

A. Right now it's considered the fourth leading cause of death in this country, probably soon to be number three, if it isn't already, because strokes are number three, Strokes are on the decrease, Alzheimer's is on the increase, probably because of increased knowledge and making better diagnosis of it, You don't actually die of Alzheimer's as much as you die from the broken hip when you fall and you develop pneumonia when you're laying in bed and you can't move, those kind of things,

Q. Do you know what the cause of death in this case was?

A. Well, I know what they listed, And there is an autopsy report in the Brentwood Hospital -- excuse me, got them upside down, that's not what I want -- University Hospital report, There is tan autopsy report here, and they have *very* thorough autopsies, I might add.

And let's see, that's right here. And, um-m, see, get all these things together. Okay. It's in

there, I don't think they absolutely -- I read this again last night, I don't think they really absolutely said cause of death, They didn't say, thia is the absolute cause, which I thought it was unusual because usually they say that, but they gave the clinical diagnosis and it was severe dementia, Alzheimer's -- excuse me, Alzheimer's dementia, multiple infected decubiti, then like I said, the congestion of the tissues. Those were the basic findings.

Also found some Parkinson's disease, although that: was not described premorbid. I never saw a report: of that, She had some osteoporosis, but they list as the primary -- when you say diagnosis primary, they had decubitus ulcers, multiple, infected with Proteus is what they listed as number one. Now, I am assuming they meant that was the most important.

Q. What does visceral congestion in the lung mean?

A. Well, usually you see that, that seems that that comes often at the time of death? they *go* into failure, they have a cardiac vascular collapse, and often from pulmonary congestion, liver congestion, they may have! it in other organs, not necessarily cause of death, it's an accompaniment of death. It's kind of an end stage! as everything starts falling apart,

Q. Is it similar to pneumonia?
A. No, it's mors of a passive congestion, similar, more similar to heart failure.
Q. By the way, how much time did you spend preparing for your deposition today?
a, Three to four hours.
Q. And when was that?
A. Last night,
Q. And how much time did you spend prior to issuing your November, 1988 letter report?
A. T can tell you exactly. Seven and a half hours, I think that's what: 3 billed him for.
Q. Bas he paid you?
A, Yes.
Q. And what about for your February of 1989 report?
A. Actually that was one inclusive sum for everything, I did, you know, I didn't rebill him for any, far a second letter or anything.
Q. So your seven and a half hours was put into preparing the November '88 letter?
A. Yes. And the other report was, you know, just: a function of sitting down and rewriting it and putting it in a better form in maybe ten minutes, fifteen minutes,

Q. Have you treated patients like Willie Wilhoite?

A. Yes.

Q. And how long does it usually take fox decubitus ulcers to form?

A. To what stage? You mean just in general where you see the first evidence of it?

Q. How about when you see the first evidence of breakdown of the skin, an ulceration'?

A. Okay. Depending on the condition, they start -- let's assume they start in a healthy condition, If someone who broke their hip basically, okay, goes in and sits there, probably look at anywhere from seven to ten days of immobility.

Q. Why don't you take somebody in the condition that Miss Wilhoite was in in April of 1987.

A. Oh, I would say probably easily happen within three to five days, start getting the initial stages of the redness, start breaking down the tissue very quickly, I would say.

Q. Okay.

A. Less than a week.

Q. Can even be as short as 48 hours?

A. To get the redness, yeah, sure. I don't think a tissue could break open in that period, but they

get the initial signs I would say within 48 hours, sure.

Q. Is it more difficult to recognize inflammation of the skin in a Negro person?

A. I think so, a little bit harder, yeah. Depending on, again, there is different shades. Obviously there is lighter skinned Negroes and there is darker skinned Negroes. A darker skinned Negro is harder.

Q. Do you know whether Miss Wilhoite was a light or dark skinned person?

A. I have no idea.

Q. You've never seen the photographs from the autopsy?

A. No.

Q. Dr. Norman, do you hold the opinion that Dr. Rainey's care of Miss Wilhoite deviated from the accepted standard of care?

A. Yes,

Q. What is your definition of standard of care?

A. Standard of care is what is being done where you live, how you take care of somebody, not in Boston, not in, you know, not -- in the area that you are residing what is done, what everyone usually does that io considered normal,

Q. When *you* testify that his care did deviate

from accepted standards, you are including within your geographical area --

A. Yes.

Q. -- the northern Ohio, Cleveland?

A. I know how we practice, how we practice here, basically how they practice elsewhere. People do things different in different parts of the county. I am saying northeast Ohia.

Q. Tell me in what way you believe Dr. Rainey's care deviated from accepted standard of care.

A. I feel a couple things. One, patient was obviously malnourished when she left Brentwood Hospital. She wasn't up to muff because her admitting -- when she left there her albumin was 2.9, Okay, That's one risk factor, she was poorly nourished,

Her physical state, because she was contracted. Okay, Those are two risk factors right there. Immobility obviously is a risk factor for decubiti; and so one would anticipate that this woman is going to break down fairly rapidly unless measures were taken to prevent that,

And I feel in part, and more so with the nursing horns, but I feel in part that, as always, it is the physician's responsibility and you should -- that should set off a signal, this person is coming in,

they're malnourished, they're apparently practically in a little ball, they're contracted, In a geriatric patient, a this patient is brought in with pneumonia, bladder infection, if I don't do something to try to change that -- one of the problems I had was there was no evidence that there was any attempt to discover, after the patient was admitted, nutritional status,

To me, and you know, you know that patient is at risk and you know they can't heal decubiti if they don't have a better nutritional status. So she came in with so many -- you know, I feel you need to make some effort to make sure that caloric intake is enough, and you need to make sure that you're getting enough protein and other nutrients that you are going to maintain that. There was never any lab work to document that. That was one thing,

And the other complaint was that the decubitus that was tan centimeters when the patient was admitted to the Huron Road Hospital, and even at Dr. Rainey's admission note saying it was large, be didn't define it, he just said, "Large left buttock decubiti," that was never, never mentioned at the nursing home. They just don't form over night, it had to have been missed. And that was the worst of the lot, and that may have been the ultimate, the ultimate problem of why she

was infected in the first place, because the other ones weren't as bad as this one, which no one seemed to know was there,

I feel it had to have been there several seeks at the size that it was, and was the major reason she ended up with the Huron Road hospitalization. The other ones were infected, too, but that was the biggest, the worst of the group.

Q. The bottom decubiti?

A. Right. From their description was the worst one.

Q. Well, had you been treating this patient how would you have treated her differently?

A. Well, when she would have been admitted, as I usually tell the residents, you have to measure nutrition status. How is it? Weights in nursing homes are worthless, they can't -- weights vary so much, really can't use that as a good guideline, So you have to see the person? obviously, which he did, make some calculations on how many calories they're going to need for What you see that is there.

And I don't claim any expertise, I have a dietitian see them, just as she did when she was in the hospital, Okay, Tell me what I need far this, They have got formulas, they'll tell you you give them that

much food if they can tolerate it, and then you cheek in two weeks, Maybe, you know, I like to get one in at least two weeks if someone is being tube fed, Tube feedings are notorious, even though they tell you on the label it provides all the stuff that they need, often they're going to be deficient, particularly in sodium and possibly in calories down the road if you are not careful.

I usually in two weeks will get some kind of a chemistry profile, then at some interval, maybe a month later, depending on how much I have to give them, so I have some knowledge of what the nutritional status is. Then when the temperature goes up you are increasing the metabolism, you know you are going to need to give something more. If it stays up for any length of time, I would have re-@valuated.

When the fever had been up for five weeks or something, I know they're going to need something because it's a hypermetabolic state. Outside of that, other than rolling her over, you know, when X make visits X don't, I don't check every inch of skin every time, it's very difficult, Often they're incontinent, the odors are horrible so, you know, if I am not hare this week, the next week when I come back and see a couple people, make sure I got there when they're clean, make

sure you look at every square inch,

You have to do that on first admission, you can't: always rely on the nursing home to tell you, "Gee, there is a bed sore there," *you* have to look yourself, And so I would have, would have looked in all the little funny places, behind the kneecaps, on the pressure spots, and would have monitored nutrition better,

Q. How many calories, based upon your review of this record, would Miss Wilhoite have needed to maintain proper nutrition?

A, I would have felt at least 2,000.

Q. Okay. Dr. Norman, haw many calories was she receiving if she was on a pureed regular diet with --

A. I am sorry.

Q. -- full strength Osmolite 300 cc's four times a day?

A* Okay. Well, in the nurse's notes she didn't eat very much, It's always, "Poor appetite, hardly took any," So the feeding, the oral feedings were almost nil, Sometimes she didn't: eat anything. *So* even if we give her a really good day, maybe she took in 500 calories; but generally it's five percent diet, ten percent hardly anything, I don't think that was a source to hardly cap most of the time. 300 cc's of Osmolite is almost one to

one on these, unless it's called two calorie, Unless it's a specific two calorie, they always are basically one cc to one calorie, EO it's fairly easy to calculate,

So she would have had 1200 calories for the Osmolite, and like I said, from what I can see in the nurse's notes, a very poor oral intake. I don't think you can count more than: a few hundred calories at best from her oral intake, Most of the time she was not responsive or, you know, they said that she wasn't alert or awake and they couldn't Peed her. And that didn't change for several weeks.

Q. Do you have any criticisms of Dr. Rainey's orders regarding nutrition?

Ab Other than I thought she needed more, more nutrition, land I think It's conceivable that, like I said, that's something you get from the nursing home. The nursing home would say, hey, this person isn't eating, I don't know if they ever did, there's no mention that they told him she wasn't eating.

Q. That's really my question, If he orders a regular diet with the Qsmolite supplementation, should she have been getting enough calories to maintain proper nutrition?

A b Oh, yeah. If she ate. Usually the standard nursing home diet, regular diet's about 17, 1800

calories. Sa if they get that plus 1200, she should have had plenty,

Q. Because your testimony is that she would have needed about 2,000 calories a day?

A. At least. They calculate at 2400, I would say at least 2,000. That's not my expertise, but they calculated at Huron Road that she needed 24, which is fine with me, At least 2,000.

Q. You don't have any criticism of Dr. Rainey's orders regarding nutrition?

A. No.

Q. And you feel that these orders were appropriate?

A, Yes.

Q. What should Dr. Rainey have done had he been notified by the nursing home that she was not consuming her full regular diet?

A. Increased either the frequency of the two feedings, they were giving them four times a day, either increase the frequency or the volume. 300 cc's is about maximum of what you are going to get in anyone, you know, Stomach doesn't hold tons and tons of this stuff. Usually just increase the frequency, which is what he did later.

Q. When he was notified or when he realized

that her nutritional status was diminished?

A. When he realize the -- yes, from what I could tell,

Q. Then your other criticism is relating to the buttock decubitus, Is it yout testimony that Dr. Rainey should have seen the buttock decubitus upon Some of his local examinations at some point?

A. Yes.

Q. Okay, When would that have been?

A. Particularly, let's see, when ha saw him on the 16th -- saw hex on the 16th of April it's conceivable it wasn't there, then when she was admitted to Ambassador there was no mention of it, There is no mention on the Brentwood, no mention on the admission record, assuming it wasn't there. Then he again saw her when she started getting sick around the 20th, 21st of May, Mad to have been there! then. There was no mention to show me -- when you're looking for source of infection, you check the urine, which he did, check the chest, which he did, and --

Q. Those two things were appropriate?

A. Those two things were appropriate, but also look at you know she's got bed: sores and you know they *gat* infected, so you start looking around to see, are they infected and where are they? Because, you know, to

get those better you generally have to clean them out, so that's part of the treatment, so you would be looking for those things.

Q. Do you know whether -- strike that, Do you know what physical examinations Dr. Rainey performed in May of Miss Wilhoite?

A. In May? I can, I got that, Let's see. Okay, Let's see, I have it right here,

Q. When you find it tell me what you are looking at so I can find it in my records.

A. Well, right now I am looking at the wrong one. This is what I want. I am looking for his progress notes,

Q. I think it's on an order form, Doctor,

A, Yeah, it is, I had these things set. There we go,

Okay. So on the 18th of May he has the peg was blocked and it was flushed and cleared. So that was really no major exam, he just looked at the tube. Then it looks like the 20th, because I have copy, there is a little funny looking, but it looks like the 20th, which goes along with some orders that he wrote,

He wrote -- he -- obviously he examined her then and he specifically says, "No buttock decubiti," which it seemed odd that he would mention there was none

there, but then he mentions that there were -- a guess that's eschar of the left knee. So he looked at the legs, poked on her abdomen, listened to her lungs.

Q. Examined her buttocks?

A. Listen to the heart.

Q. Examined her buttocks?

A. According to this he says that. I can't, you know, I said a can't believe that there wasn't one there! it's too big, it takes too long to form those. And you know, it seems strange to me that: you would say that unless were you expecting to find one and someone said, gee, hey, I think someone has one an their buttock. Did you look? No. 2 would look and then you write that. But, I don't know, but that was on the 20th of May.

Q. Doesn't the notes from Dr. Rainey's -- strike that, Don't the notes from Dr. Rainey's 5/20/87 examination appear to reflect a rather thorough examination of Miss Wilhoite?

A. Reasonably thorough, yes,

Q. Wave you, in your skimming Dr. Rainey's deposition, read the portion of his deposition relating to the examination he conducted on May 20th, *19871*

A. I may have, but I don't remember it.

Q. Is there any way that you can reconcile your belief that this decubitus had to be present with DE.

Rainey's note there that there was no buttocks decubiti?

A. I can't reconcile that at all, because on the admission to the hospital on the 28th, well 28th, 29th, the admission note was a large decubitus of the buttock, then later described, unfortunately four, five days later, of a size, but large -- to me large is at least that much, (indicating) and they just, I just can't believe, 3 have seen too many of them, they take too long to get that big.

Q. What size would you characterize a large decubiti or decubitus?

A. If I said large I would say one about like that, (indicating).

Q. Fax the Court Reporter's sake --

A. Eight centimeters,

Q. Eight by eight or --

A. Yeah, eight by eight. I would call that large, go eight by eight.

Q. And how long would it take for a decubitus to form of that size?

A. Several weeks.

Q. Even in a patient the condition of Miss Wilhoite?

A. In a healthy person it would take months and months, but in her condition it's going to take three or

four days far the skin ta start to break down, just to get the redness, You are going through the fat layer, There is more fat in the butt over Chis area right now, it's not like over an ankle where the bone is right against there, they break down much faster. So she's got some extra stuff there. And you know, from my experience, I can't quote you a research project, from my experience it take6 several months -- several weeks, excuse me, two, three minimum, to get that: big,

Q. Have you ever seen *a* decubitus ulcer that *size* form in a shorter period of time?

A. Never.

Q. Do you think Dr. Rainey had a reason to -- strike that,

When the decubitus is described in the Huron Woad records, you are saying that that was four days after her admission to Huron Road Hospital?

A. It was an the 2nd. 16 sticks In my mind, Let me look. Okay. There was a note, It didn't give an exact: measurement, on 5/29/87, It says, "Left buttock with large, greater than ten centimeter, eschar." The actual something by something, I didn't see that until the 2nd, but his admitting note on the 29th just says greater than ten,

Q. What does that mean to you?

A. That means it's quite large. It's an eschar, so it's necrotic. Necrosis at that size to me again takes several weeks, two, three,

Q. Ten centimeters being the square?

A. 3 would say from rim to rim, what that means to me.

Q. Doesn't mean five by two centimeters equaling -- totaling ten centimeters?

A. No. You don't usually do it by area, Most people measure eschar's diameter,

Q. The greatest width or the greater length?

A. Yeah, that's what that would mean to me. One of the dimensions is greater than ten centimeters, either this way or this way, (indicating),

Q. And when was that, Doctor?

A, That was on 5/29/87.

Q. So nine days after Dr. Rainey -- that was nine days after Dr. Rainey had last examined her?

A. Pes.

Q. Dr. Norman, is it your opinion that Dr. Rainey's deviations from accepted standards of care proximately caused an injury to Miss Wilhoite?

A' Caused it, no. Helped it along, yes.

Q. In what way did he help it along?

A. The two that were previously mentioned,

nutritional status and lack of early observation,

Q. But these deviations, as you suggested -- strike that.

The deviations from the standard of care that you have testified about that were committed by Dr. Rainey did not: proximately cause an injury to Miss Wilhoite?

MR. DELBAUM: I want to abject unless you explain to the witness what proximately caused means. Do you know what proximately caused means, Doctor? If not you are asking --

THE WITNESS: Actually, no, I was trying to thfnk of that myself,

BY MR. SEIBEL:

Q. Did any deviation from the standard of care on Dr. Rainey's part cause in fact any injury to Miss Wilhoite?

Q. What injuries?

A. Um-m, probably her admission to Huron Road Hospital because of a very large apparently infected and necrotic decubitus may not have been prevented, but certainly could have bean treated earlier and more judiciously. That was the worst of the group, it never healed, so in that respect it just added to the burden of

what she had already,

Q. So the injury that his deviations caused was her admission to Huron Road Hospital?

A, I think so.

Q. And the treatment that was required at: that hospitalization and thereafter?

A. Yes,

Q. Okay, Dr, Norman, assuming Chat there was no buttock decubiti or decubitus on 5/26/87, did Dr. Rainey's care fall below the accepted standards of care?

A. A little.

Q. Okay, In what ways?

A. I am still with the nutrition. Still, the other ones still progressed,

Q. The other -- which other ones?

Ab The other decubiti were still bigger, Irregardless of whether there was one an the buttock, they progressed, and without adequate nutrition they couldn't help but progress, and so they're still a nutritional issue,

Q. You testified before, and I went to make sure that I understand you correctly, that Dr. Rainey's orders for nutrition were appropriate, yes?

A. His orders were, yes.

Q. And do you know what treatments Dr. Rainey

ordered for the other decubitus or the other decubiti?

A* They --

Q. We arc talking about hsr first admission to Ambassador, correct?

A. I thought that's -- yeah.

Q. I want to make sure of the context of the question,

A, Okay, Were, Get these mixed up, Can I say something off the record? I know the original -- I am talking out loud, I know the care was -- I thought that was standard, Let's see. There was a crepe mattress.

Q. That was an appropriate order?

A. That's an appropriate order,

Q. Let's take them one at a time.

A. Okay,

Q. So what was the other one?

A. That's one that was appropriate. Used ankle protectors, Which is appropriate. Questionable. Some people say they don't work. Elbow pads and heal pads he put on. It's considered an acceptable preventive measure.

Q. Were there any decubitus ulcera that he did not treat?

A. Well, on the buttock.

Q. Well, Let's assume that the decubitus ulcer

vas not there as of 5/20/87.

A. Okay,

Q. Were there any ones that he didn't treat?

A. Let me look at my notes here, Well, let me put it this way, They were necrotic and infected when they were at -- when she arrived at Huron Road. Now, there was no description adequately in the nurse's notes or anywhere else necrosis and that much infection at the nursing home,

If they weren't necrotic and infected there, which I have a hard time accepting, then the care was adequate. If they were necrotic, the care was Inadequate.

Q. In what way?

A. Necrosis always needs to be debrided, you need *to* clean it off, It won't heal by itself. You can either do that physically by literally cutting it *ox* do it by chemicals, things that dissolve it, And that's the only way you can heal something that is necrotic, you have to clean it out. That was not done.

I can backtrack and say that it's hard tu know how they could get that necrotic that quickly without: it baing present at the nursing home,

Q. Are Betadine scrubs a debriding methodology?

A. Um-m, minimal.

Q. It does serve to debride?

A. Minimally. It couldn't shake,an eschar off, which one was noted by him on the one inner knee. It will take fine necrosis, but not an eschar, which is a hard scab, like leather.

Q. But Betadine scrubs will debride necrotic tissue?

A, Not that kind, not an eschar,

Q. Let me ask it this way. Does: -- strike that. Do Betadine scrubs debride necrotic tisaue?

A. Certain kinds, yes.

Q. Doctor, based upon your review of the records did Dr, Rainey's deviations from accepted standard of care cause Miss Wilhoite any pain or suffering?

A. Am I allowed to talk about the buttock decubitus?

Q. Well, let's ask It two different ways. Assuming that the buttock decubitus was not present OR 5/20/87, did Dr, Rainey's deviations from accepted standard of care cause Miss Wilhoite any pain or suffering?

A. Some, because the eschars weren't removed, which promulgated the decubiti to become bigger because they weren't clearly treated, They can be very

uncomfortable, The odor could be extremely foul, which was described as having foul odor in the hospital, To me that's uncomfortable having to smell that every day. And they cause pain because they hurt, the raw tissue, So in the fact that they weren't, In my opinion, adequately treated, yes, it did produce some pain,

Q. What eschars are you talking about specifically?

A, Well, the one, she had one on her -- better not say that until I look it up. I need his -- okay, He clearly said she had one on the left inner knee per his statement: on the 20th of May.

Q. Any others?

A. The admission there were others on the toes, on the buttock, on the heals, they pretty much were there on and off throughout: the admission,

Q. But you are saying that the eschar on the knee was the one that would have caused her some pain?

A. Caused some pain,

a. Do you know what treatment Dr. Rainey rendered for that?

A. The same as for the other ones, with the Betadine cleansing, the dry sterile dressings that were used, He didn't have any pads on those, but those were the basic treatment until an antibiotic was started,

which was started for pneumonia, but would have helped with the decubitus, It's a good broad spectrum antibiotic.

Q. Do you know when that antibiotic was started?

A. On the 21st.

Q. The day after the eschar on the left knee was noted, correct?

A. Correct, yeah. 5/21/87,

Q. So she would have had one day of paint is that what you are saying?

A. Well, we don't know how long that eschar was there before because it wasn't described, It could have been there, he didn't see her after the 16th of the previous month, Did it start five days after that? I have no way of knowing that, Could it have been one day? Eschars don't appear that fast, I would have to say it had been there for a few weeks,

Q. Is there anything in the nurse's notes or anything in the records of the nursing home that would help you with when that eschar formed?

A. They really didn't go into any details in their description of it. I have, I have that.

Q. Do you want to take a moment and look through the records or do you want to move on?

A. I have it right here. According to this it appeared on the 20th is the first time it was noted, and it was two by two centimeters at that time, That's when it first appeared, They say it's pink, he says there is an eschar the next day.

I mean actually on the 20th he says -- I am sorry, excuse me, on 5/20 when he Bees it he calls it an eschar, The nursing home calls it pinkish white on that same day, and that's when they first noticed it on the decubitus report,

Q. well, let's; be fair to Dr. Rainey. I believe he does call it a developing eschar, not really a formed eschar.

A. Right, but it's still not pink. I was being fair to him, I wasn't being fair to the nursing home. I think his is right, 3 think theirs is wrong.

Q. Dr. Norman, do you have an opinion as to whether any deviation from the standard of care by Dr. Rainey directly led to Miss Wilhoite's death?

A. In a certain respect. I can't say absolutely her demise was directly related to his care, I think overall he gave very good care. Of course the parts that I already mentioned that I think was deviation that may have sped the process up, decubiti got worse when I think they should have been treated a little bit;

better, It may have, it would have had happened irregardless of whether this left one was there, buttock one was there,

Q. She would have died regardless of the buttock decubitus?

A, The other one6 were getting bigger anyway, I just felt that that contributed because of the nutrition. It was never adequately taken Care of, The debridement which would have been necessary for that to heal was not done, so there was a contributing factor by his care,

Q. Do you think there was any way that this woman -- strike that, Do you think there was any way that any physician could have prevented this woman from developing decubitus ulcers?

A. No. Sometime, if you will give me a length of time, I don't think anyone could have overall. I don't think the woman had anything going for her that was going to produce long-term survival. I think the process was sped up, but I don't think you could have prevented them.

Q. So the decubitus ulcers in her case were eventually going to claim her life; is that what you are saying?

A. I can't say that. Pneumonia -- let me just

put it this way, Other causes of immobility, which go along with immobility, pneumonia, decubiti or bladder infection, would have been the ultimate demise, I would guess, irregardless.

Q. Can you state to a reasonable degree of medical probability that Miss Wilhoite would not have died at the time she did had Dr. Rainey did the things you suggested he should have done?

A. No, I can't say absolutely, May I, this is --

MR. SEIBEL: Off the record.

(Discussion had off the record,)

MR. SEIBEL: Let's go back on.

BY MR. SEIBEL:

Q. Doctor, I understand that *you* have some opinions that are critical of the nursing home care in this case. Do you have any other opinions -- I don't want to ask you about those, that's not my job, Do you have any other opinions in this case as to the care rendered by Dr. Rainey?

A, No.

Q. Doctor, do you agree that Dr. Rainey -- let's start over again,

Do you agree that Dr. Rainey's care was appropriate while Miss Wilhoite was under his care at

Huron Road Hospital from May 28th, 1987 through June 8th of 19871

A. Yes.

Q. Okay, And do you agree that Dr. Rainey's care was appropriate when Miss Wilhoite returned to Ambassador Nursing Center from June 8th of 1987 until August 5th of 1987 *-

A. Nut quite.

Q. -- while she was under Dr. Rainey's care?

A, No.

Q. Okay. Why?

A. Part of the same problem. The decubiti, which now have grown quite large in June, from June, July end August, they all are listed as necrotic in a11 the descriptions, and again I come back to the point that if you are going to treat them, maybe they had decided, whomever, that these were beyond any treatment, which they may very well have been, but it was never mentioned. And if you can -- again, if you are going to treat decubiti and they're necrotic, they will not heal ever unless you clean up the necrosis.

So that's -- the nutrition was adequate at that time, no problems with that, but: I still. come back to the same point, that's the treatment *for* necrotic decubiti, We have to get rid of the necrosis by chemical

or physical means, and that was not done.

Q. You find no evidence in the nursing home records from June 18th of 1987 until August 5th of 1987 of any debridement whatsoever?

A. Not the kind I mentioned,

Q. Do you find any evidence of any debridement?

A. Well, you know, when you put dressing on and take them off you are going to pull dead tissue off.

Q. So that's debridement?

A. That's a form of debridement. That wouldn't get eschars off; that is a form of debridement, yes,

Q. I assume that you never had the opportunity to examine Miss Wilhoite,

A. Correct,

Q. Dr. Norman, do you regularly use or rely on any textbooks or journals in your practice?

A. Textbooks? For certain things, a broad overall, they usually weren't current on what is happening medically. Generally that would be magazines, you know.

Q. Journals?

A. Journals. But I do have some.

Q. Which textbooks do you rely on?

A. Riechel's, R-I-E-C-H-E-L's, Clinical Geriatrics is my favorite, and Principles of Geriatrics

by Andres, A-N-D-R-E-S, are the two that I, I look up broad topics in.

Q. Even as of today in your practice you rely an those Journals?

A. Yes*

Q. Do you find those helpful in your practice when you refer to those journals?

A* Those are textbooks.

Q. I am sorry. When you refer to those textbooks?

A. Yes.

Q. Nave yau utilized those textbooks in formulating your opinions hers today?

A. I honestly can't say if the information came from there or from journals, because E read mostly journals and refer back again from broader topics, but the exact spot of knowledge I couldn't tell you.

Q. What journals do you use and rely on in your practice?

A. Journal of the American Geriatric Society, Geriatric Clinics are the two I would say most frequently, And another one which is called Geriatrics, it has something else to it, but that's how I know it as.

Q. Doctor, do you expect to appear live at trial?

A. Wasn't expecting to.
Q. Are you going to bet?
A. I am not sure.
Q. as your testimony going to be videotaped?
A. I don't know when it is.
Q. There is no trial set in this case, but is it part of your arrangement with Mr. Delbaum that you will appear five at the trial?
MR. DELBAUM: It hasn't been -- it's an issue that hasn't been discussed. Isn't that right, Dr. Norman?
THE WITNESS: Yes.
BY MR. SEIBEL:
Q. Doctor, what is the recognized method of debridement of the decubitus eschars or debridement of decubitus ulcers?
A, If you have soft necrosis, generally normal saline or Betadine gauze, put it on wet and it dries, you pull it off the next shift and it takes some of that loose, dead tissue,
You can either use that or something Pike Elase, which is E-L-A-S-E, which is a necrotic -- chews up necrosis, it's like Drain-O.
And then when you have an eschar, when you have a hard scab or leathery thing, you can still use the

Elase, preferably if you cut holes to help it get underneath it, or you physically remove it, which is considered the best technique, with scissors or scalpel.

Q. Is hydrogen peroxide a debriding agent?

A. No.

Q. Okay, What is the purpose of hydrogen peroxide3

A. Personally I don't think it's any, I don't consider it a good cleansing agent. Other people use it because it bubbles and by that very action helps clean things, it gets dirt and stuff out. I am not a proponent of using that for pressure sores.

Q. Is there any particular progression of debridement that you would engage in as a physician for necrotic issue?

A. I like to clean it up with scissors. I go in there first and cut it off.

Q. That's your first choice?

A. Yeah. Takes too long if you use Elase. I Personally like to cut the scab off first, and then depending -- obviously can be uncomfortable for the patient, you hope you can got a plastic surgeon to do it if it's possible, If they're bad enough you can take them to the hospital and give them anesthesia. If not, usually you taka off the sore, than what I tend to use is

either Betadine wet to dry or the saline, as I previously mentioned, after the eschar's off, or Elase because it's much less painful,

Q. So your first approach to debriding necrotic tissue is to actually cut it away?

A, I trim as much of it as I can, and then I try to use less painful. things, Necrosis doesn't hurt, so the dead tissue wouldn't give any pain when you remove it until you get close to the live tissue, So I get the bulk of it off with scissors, and then preferably use other things,

Q. And that's without anesthesia?

A, True,

Q. Doctor, do you have an opinion that Hiss Wilhoite's temperatures during that first admission to Ambassador in April and May of 1987 represented an infection?

A. Yes.

Q. Okay. Why?

A. I think she had the decubiti on her buttock and that it had been there for several weeks. And I think the other ones were probably starting to get infected. There is no other symptoms at the time, I assume that's why it wasn't addressed any more than it was, because she doesn't have anything different, I felt

that they were present at the time being infected,

Q. Can you, based upon your examination of the records, can you think of any other reason why she may have been running a low grade temperature?

A. For that period of time, no.

Q. Is it possible that that temperature range could have been normal for a person in her condition?

MR. DELBAUM: Objection.

BY MR. SEIBEL:

Q. You are allowed to answer.

A. I am sorry. Normal for her?

THE WITNESS: Can I have that read to me again?

(The previous question was read back.)

THE WITNESS: No.

BY MR. SEIBEL:

Q. Doctor, is it true that rectal temperatures are usually a bit higher than oral temperatures?

A. Approximately one degree, yes,

Q. So would a rectal temperature of 100 be considered normal?

A, Most people, depending on what you started from, If you had a base line, if that person always was, they're always 87, then a hundred is a little more exciting, If they were always 98 or 99, then a hundred

would not be exciting,

Q. And how much over a hundred for a person with a base line of 99 with a rectal temperature would you be concerned about?

A. About 100.5.

Q. So anything from 100.5 and lower would not concern you as a physician?

A. It would concern me. I would pay attention, I tried to see, is this a normal temperature for that person, or is there an infectious etiology?

Q. And if there was, if that -- in fact those temperatures were normal for that person, those temperatures would not require response from you as a physician; isn't that true?

A. True.

Q. And those normal temperatures would not necessarily be a sign of infection; is that correct?

A. True.

Q. Dr. Norman, did Dr. Rainey respond appropriately when he was alerted to an elevation in Miss Wilhoite's temperature?

A. Pretty much so.

Q. Do you find any problem with the way he responded to the temperature elevation?

A. Again, I am still not sure about the

decubiti, how accurate they were looked at, but as far as everything else, I have no problems with it.

Q. Are antibiotics always required for decubitus ulcer management?

A, No.

Q. When would antibiotics be required Ear decubitus ulcer management?

A. When they're infected, purulent,

Q. Are there risks to antibiotic therapy in decubitus ulcer patients?

A. Sure.

Q. What are those risks?

A, Depending on how they were given, in this case say intravenously, obviously in anyone you have a potential for allergic reaction. You never can tell about that, They may induce diarrhea, which would dehydrate somebody, or fairly further deplete nutrition, Certain ones produce renal failure, definitely, so there are multiple potential side effects.

Q. Superinfection?

A. Seeps, yeast vaginitis, particularly in women,

Q. Do you suggest, with respect to your opinions about Dr, Rainey's care in this case, that he should have intervened earlier with antibiotics with Miss

Wilhoite?

A. Not necessarily, no.

Q. Dr. Norman, if responsibility for Miss Wilhoite's condition is shared between Dr. Rainey and the nursing home, what proportion of that responsibility is Dr. Rainey's?

MR. DELBAUM: You mean specifically with respect to the injury she suffered in this case?

BY MR. SEIBEL:

Q. In her condition. And how Would you apportion that responsibility?

A. Twenty percent Dr. Rainey's, eighty percent nursing home.

MR. SEIBEL: I don't have anything further.

MR. DELBAUM: Let's go off the record far a moment,

- - -

BY MR. ROBERTS:

Q. Dr. Norman, my name is Neil Roberts and I represent the Ambassador Nursing Rome, I am going to try to keep this as short as possible.

First of all, prior to being involved in this case did you ever have any knowledge of the existence of Ambassador Nursing Borne?

A. Never heard of it,

Q. Never heard of it, okay+ Since being involved have you acquired any knowledge of the Ambassador Nursing Home?

A. Haven't discussed it with anybody.

Q. Okay. Now, you were discussing previously the standard of care for physicians in the position of say Dr, Rainey. And now E would like to talk about the standard of care of nursing homes, I assume you are also familiar with that standard of care?

A. I would like to think so.

Q. Okay, And from your testimony, I understand that you have found a number *of* deviations in the care given by Ambassador Nursing Home to Willie Wilhoite,

A. Yes.

Q. Okay, Could we go through those, one at a time, what: those deviations were?

A. Okay, Let me get my -- can you wait just a second? Get these in order so when I have to look something up --

Q. Sure*

A. -- I know where it's going to be,

Okay. I think there was poor observation abilities on the nursing home personnel, which I think you have to rely on extensively as a physician, because

they're there every day. They bathe people, they dress them, and they should see these things happening, i.e. decubiti, at the earliest stage, okay, because they look at them every day.

I don't feel there is any evidence that that was done to the level I think it should hove been, They wrote, "turned every two hours," and they bathed them. But you know, these things got bigger without any apparent notice by them. I find that, I think they were --

Q. Which ones are we talking about now?

he I am sorry, which --

Q. Which decubiti? You said these things got bigger.

A. All of them, And the nebulous buttocks one, whether it was there or not, which I feel it had to have been, the other ones still progressed with minimal -- I can't find anywhere in the nurse's notes that this was conveyed to Dr, Rainey with, you know, saying these are getting bigger, you know, we found this or that. I don't see that in the nurse's notes or in the orders from the nurses.

Q. Okay, So they should have observed Mrs. Wilhoite more closely and communicated their observations to Dr. Rainey?

A. They're bathing her, they should have seen these things. That's one point. A second point is she clearly was not eating, and they note that in the nurse's notes. Dr. Rainey, of course, is not going to be there every minute of the day, now would anybody, That should have been aggressively, more aggressively brought to his attention, He relied, had lo rely on them for that information,

Q. Re wouldn't, as a matter of course, read their notes?

A. You know, he is not going to be there every day.

Q. I understand.

A, When he come in on the 16th, you know, everyone adjusts to nursing homes, First week or two people often act really different, and so you have got to let them settle in, Then you have *to* rely on the staff to say, okay, this is what we found, thio *is* what they're eating. You just can't be there every day and look over their notes, And I think that should have been conveyed to him and I don't think it was.

Q. Okay. Anything else?

A. Those are my *two* main issues.

Q. Basically they're the same two issues that you have with Dr. Rainey, but it's your belief khat the

primary responsibility should have been on the nursing home?

A. Absolutely.

Q. Okay, And 80/20 is the way *you* put it?

A. Good guess in my mind, *yes*,

Q. All right. That's all anybody can do, I guess. I don't want to go back over everything that you have testified to as to Dr. Rainey. Basically your testimony would bo the same as to the nursing home, I take it?

A. I will guess if the questions were the same.

Q. Okay, Anything you can add as to the nursing home that you didn't testify that the nursing home did wrong that Dr. Rainey did not do?

A. Other than what I mentioned, I think they're clearly at fault for the decubiti getting worse. They say they turned them every two hours,

Q. Do *you* have any reason to disbelieve that they turned the patient every two hours?

A. Yeah, because the decubiti got so much worse, I really feel that I question whether they did that, I have no way of knowing, of course, but I question it*

Q. Okay, Now, I believe you testified that what you perceived to be Dr. Rainey's deviation in his

standard of care may have sped up the process of Miss Wilhoite's death.

A. Yes.

Q. Would your testimony be the same as the nursing home??

A. I don't think they sped it up, I think they caused it.

Q. Caused it, okay. And because of these two things that we have just mentioned, the poor observation and the patient not eating and those factors not being communicated to Dr. Rainey, those are -- were they causes of Hiss Wilhoite's death3

A. In part, I feel, as I said, their turning schedule, I am not sure if they maintained it, I had an overall impression, if that's fair to give an impression, that they grossly understated the decubiti.

These things look meaningless, I mean, they look minimal, This is the first admission. Their description on hero, they're all stage -- nothing is worse than a stage two, and they looked, all the way up to the 27th of May, and there io stage three and stage four one Bay later or two days later at Huron Road,

I think they painted a fairly good picture when I can't see how it possibly could have existed, They're talking pink, white, healing, These are the day

before she was admitted ta the hospital when they say they're black, they're necrotic and they're infected. I don't think they jibe, I think they under-reported what was happening, That's my impression.

Q. Do you know of any reason why someone in that position would under-report what was happening?

A, Actually, no, because I think you get paid more for the more care you have to render; but also it reflects on the nursing home. People gat bed sores, pressure sores, which I think would make one believe that the nursing home isn't any goad. So they would have that PR move, if nothing else, to try to make it look like things don't look so bad.

People come to review and they say, wait a minute, these decubitus look better and better, that's what they're supposed to do, Reviews would look at this, they'll be happy. That would be a reason.

Q. If a understand what you are saying, it is that the nursing home actually caused the decubiti?

A. I don't think X can absolutely say that other than the fact that that's my gut feeling; that they did not turn her as they were supposed to, They didn't observe, you know, these things jump right *off* to stage two's for the ones on her knees, they never see it as a stage one, They should have picked that up then. They

didn't make it happen possibly, but a stage one is a whole lot easier to t eat than tw or three, and they didn't even see it as s stage one. You don't suddenly have a two by two centimeter lesion that: appears from nowhere.

MR. SEIBEL: Let's go off the record for a minute.

(Discussion had off the record.)

BY MR. ROBERTS:

Q. Getting back as to the 80 percent, 20 percent, just so I can try to get it straight in my mind, are you saying that it's 80 percent an the part of the nursing home because the nursing home more actively caused the bed sores and 20 percent on the doctor because he didn't do something to prevent them?

A. There was a few --

Q. To cure them?

A. -- medical things that he could have Bone, i.e. the nutrition and possibly a little bit better observation, The nutrition was my big issue. That's not necessarily on a medical standpoint the nursing home's responsibility, They're responsible to observe what is happening,

They don't make a diet order per se, the doctor gives that, renders that diet order, but they're

the ones that tell me or tell him what they're doing with that diet, If the person spits it out every day or is vomiting that out every day, I need to know that observation so that I can readjust, readjust it. And it was never mentioned that that was passed on to him until way down the road five weeks later, which then he reacted to it.

I feel that decubiti don't appear over night, that they had to have seen them, If they were looking at this woman every day like they said they were, turning her every two hours like they said they were, they would have seen them before they got to the stages that they ware,

And that's purely their responsibility, because they're the ones that are supposed to be preventing these things, they're the ones that see her every day, render her care every day, wash her, bathe her, clean the stool off of her, et cetera,

And these things like just appear out of nowhere, all of a sudden they're two by two centimeters, and somehow that reporting wasn't done. They just don't appear bike that, they take weeks. And that's their responsibility clearly, as Ear as I am concerned.

Q. Well, the reporting's their responsibility,

A. And observation.

Q. And observing, okay, Now, let's assume that: they had observed and they had reported and all these decubiti were listed at whatever proper stage that: they were and the doctor was informed, et cetera. What would the normal, normal course have bean for Mrs, Wilhoite?

A. Reported when they were stage one? They just found one and it just was in the initial stage, then you are going to try to do measures *to* relieve the pressure. That may be a Clinitron bed -- should I describe that?

MR. SEIBEL: It's his question.

BY MR. ROBERTS:

Q. No, that's okay,

A. A Clinitron bed or any other bed that defuses the pressure, that's the treatment of choice, That's one of the big mega treatments. You put them on a bed like that, it defuses the pressure, so it takes away the pressure points,

If you watch them and they get a little bit infected or starting to get a little bit bigger, then you treat that with either local antiseptic treatment, at least: initially, or systemic intravenous or oral antibiotics afterwards.

When you get into stage one you can use sprays called Granulex, which is a dressing that sticks

on there to produce a harder barrier against the skin. You take them off of that, rest on -- it's something that you put around a wound so when they lay down that spat hangs more free, something called Tegaderm, which is almost like a thin Saranwrap that you put over, that you place over the Granulex. You put *it* down moist then you put the Tegaderm on there, which *is* like a Saranwrap, to prevent it from rubbing. Those things would be done well before they got to any further stages.

Q. If those things are done may those decubiti still go to further stages?

A. Sure they could.

Q. Okay.

A. No guarantees.

Q. Right, right, If all those things had been done promptly to Mrs. Wilhoite, is it possible, subject to the objection to the question, is it possible that they may have still continued to worsen?

MR. DELBAUM: Objection.

THE WITNESS: Of course they could, I would have no way of knowing for sure. Much less likely,

BY MR. ROBERTS:

Q. Let's leave aside infected decubiti and let's talk about Willie Wilhoite as she was when she first entered Ambassador Nursing Home in April of 1987.

A. Uh-huh.
Q. In your opinion, Doctor, what: was her life expectancy at that time?
A. It wouldn't be very long, I think we would be talking in terms *of* one or two years maybe.
Q. All right, And what: would the quality of her life have been during those one or two years?
A. Assuming that she had a decubitus prevented where *she* wouldn't have had pain, she would basically have been a lump in a bed, occasionally being moved from side *to* side, force fed, Quality of life would have been very poor, at least by my standard.
Q. And it would have --
A, But much less pain-free,
Q. All right, And it would have deteriorated, I take it?
A, More pain free, excuse me,
Q. From what you have described Alzheimer's is progressive.
A, Yes.
Q. So -- and that would have just kept getting worse until she died from something else?
A, I am not sure what stage she was at, because she had so many other medical problems, It was listed as moderate Alzheimer's on the report, so I would have to

assume that she had more years left, It was just up to the Alzheimer's as producing her demise, If I -- you know, didn't say severe Alzheimer's, so I would have to assume she was in the middle stages of the disease, which say she's a stage four or stage five, you are looking at still three, four, five years of survival before you become bedridden. I have no way of knowing, I am just going by that report.

Q. Okay.

MR. ROBERTS: That's all I have. Thank you, Doctor.

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BY MR. SEIBEL:

Q. I just have a couple more, Rave you read Rebecca Wilson's deposition in this case?

A. No.

Q. Doctor, is there anything in any of the records that you reviewed that leads you to conclude that: Miss Wilhoite had the ability to perceive pain?

A. She grimaced, was remarks, moaning, Very few people don't perceive pain. There is no indication that she wasn't perceiving pain that I can see. She made movements, grimaced, made noises. They could be interpreted as other things, but they can also be interpreted as pain.

Q. What can they be interpreted as other than pain?

A. Discomfort from the position they're in, which may not necessarily be pain, just uncomEortableness, just a gas bubble, It would be a brief period of discomfort,

Other mechanisms of communication, like a baby, a baby cries, it doesn't mean it's hurting, it means it wants something, so it could just be trying to get her needs across. I suppose that's certainly passible.

Q. Well, would her contractures cause her discomfort, do you believe?

a, They're painful, sure.

Q. And would the insertion of a Foley catheter cause her discomfort as well?

A. The actual insertion or the fact that it's there?

Q. The indwelling of the catheter.

A, Minimally.

a. Haw about the gastrostomy tube?

A. No, If you get: it caught on something and it yanks, but those are relatively painless. 3 have had many people awake and who were talking who had them, because they will have blockage up here, it produced no

pain in them, I don't think it would have caused any in her.

MR. SEIBEL: I don't have anything else, Thank you.

MR. ROBERTS: Nothing.

MR. DELBAUM: You have a right to read the deposition transcript to make sure that the Court Reporter has accurately taken down what you have stated,

THE WITNESS: I wouldn't mind that,

FIR. DELBAUM: I think that would be a good idea in light of some of the coughing that a number of people in the room has produced during the deposition, just *to* make sure.

THE WITNESS: Well, my speech sometimes is not intelligible when your nose is stopped up.

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(Deposition concluded at 4:15 o'clock p.m.)

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I, Robert E. Norman, M.D., do verify that I have read this transcript consisting of ninety-four (94) pages, and that the questions and answers contained herein are true and correct.

_____
Robert E. Norman, M.D.

Sworn to before me, _____
a Notary Public in and for the State of _____,
this _____ day of _____, 19_____.

_____
Notary Public in and for
the State of _____.

My commission expires _____.

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