IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

- - -

DOC 351

WILBUR HOFELICH, et al.,)
Plaintiffs,)
vs.) CASE NO. 167165
MANOR CARE OF NORTH)
OLMSTEAD, INC., et al.,)
Defendants.)

- - -

Deposition of J. JOSEPH PAYTON, D.O., a Witness herein, called by the Plaintiff 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 J. Joseph Payton, D.O., 50 North Miller Road, Akron, Ohio, on Friday, the 2nd day of March, 1990, at 2:10 o'clock p.m.

COMPUTERIZED TRANSCRIPTION BY
BISH & ASSOCIATES, INC.
524 Society Building
Akron, Ohio 44308
(216) 762-0031

APPEARANCES:

On Behalf of the Plaintiff:

Messrs. Stigi, Delbaum & Hickman Co. L.P.A

By: Charles Delbaum, Attorney at Law
Standard Building, Suite 1620
1370 Ontario Street
Cleveland, Ohio 44113-1701

On Behalf of the Defendant Dr. Suntala:

Messrs. Jacobson, Maynard, TUschman & Kalu

By: Robert Seibel, Attorney at Law
and
Steve Hupp, Attorney at Law
14th Floor, 100 Erieview Plaza
1301 East 9th Street
Cleveland, Ohio 44114

On Behalf of the Defendant Manor Care of North Olmstead:

By: Burt Fulton, Attorney at Law
6th Floor Bulkley Building
Cleveland, OHio 44115

- - -

I-N-D-E-X

- - -

JOHN JOSEPH PAYTON, D.O.

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

CROSS-EXAMINATION

BY MR. DELBAUM:

Q. Would you state your full name for the record, please,

A. John Joseph Payton,

Q. And you are a physician; is that correct?

A. I am,

Q. Dr. Payton, my name is Charles Delbaum, we have just been introduced, I represent the Plaintiffs in the action concerning which you are here to testify today. During the course of my questioning if I ask you any questions that you don't understand, will you tell me that, please?

A. I will.

Q. Have you been deposed previously?

A, For this case?

Q. No, in any case.

A. Um-m, yes, I have,

Q. Okay. You understand that another ground rule that is useful to remember is answer questions verbally rather than by nodding your head so the Court

Reporter can get it down accurately,

A. Okay.

Q. It's fine if you also nod your head at the same time. Tell me a little about some of the other cases you have testified in, What kind of cases have those been?

A, To the best of my recollection, I have testified twice. Once was a case involving, in a life insurance policy that a daughter was trying to collect on her deceased father; and the other was in a case of the mental competence of a patient that had a will drawn up at the last moment.

Q. Okay" And that's the only testimony you've given by way of deposition or trial testimony has been in those cases?

A. I believe so.

Q. Okay. Have you written reports in medical negligence cases previously?

A. I have.

Q. About how many times?

A. About average probably of one a year for the last ten years.

Q. Okay, Have those been primarily for plaintiff or defense or some of each?

A. Some of each.

Q. Can you estimate approximately how many of each?

A. I think I have written for the defense in the majority of the cases, probably nine. Say if I have done it ten times, I would say nine of them. I can only recall once when I felt that there was a reason to support the plaintiff.

Q. Okay, Have you been contacted by plaintiffs attorneys on other occasions and declined to prepare reports for them?

A. By this plaintiff's attorney?

Q. No, no,

A. Oh, by any.

Q. Any plaintiffs attorneys.

A. As a matter of fact, I have one right now from an attorney in Youngstown, frankly I just don't think I am going to have the time to respond to him. But that's the only one that I may have turned down.

Q. Okay, Tell me what. journals regarding geriatric medicine you read regularly, please,

A. The only journals that I read regularly are the American Family Physician, which of course includes geriatrics, and to a lesser extent, Post Graduate ~~Medici~~ne and GAMMA. Those are my regular journals.

Q. Are there any texts in particular that you

consult when you have a problem in geriatric medicine that you feel you need to learn a little bit more about?

A. No, I can't say that I consult any textbook per se other than say Harrison's Medical Textbook, but not -- I cannot recall pulling out a textbook that said "geriatrics" on it.

Q. Any textbook that you consult on geriatric topics even if the title doesn't say geriatrics other than Harrison, which you mentioned?

A. It would be general medical textbooks.

Q. Okay. Do you have a file that you have developed in this case including the records that you've looked at and the depositions and so forth?

A. I have information that was sent to me by the attorneys here piled on the floor.

Q. May I see what you have, please?

A. (Witness handing documents to Attorney Delbaum.)

Q. Thank you, At least one of these documents has some red underlining. Is that your underlining or --

A. Yes,

Q. -- someone else's? Okay.

A. As I read that, I believe I used a red pen to emphasize things that I wanted to talk about.

Q. Okay. Did you receive everything that I'm

looking at now before you wrote your report, or you received -- other than some correspondence, or have you received some additional records OK documents since you wrote your report?

A. No, I have not received additional documents since I wrote my report.

Q. One of the documents right here on the top, and the one I was referring to when I asked you about underlining was Fairview General Hospital Clinical Resume signed by Dr. Suntala for February and March, 1989,

I can show it to you *so* you know what I am talking about.

A. As far as I know there was just one mailing, so I should have seen. this before I wrote my report.

Q. That -- in your report you list what you've read and that's not among the documents. Let me show you your report *so* that you don't yo on my word.

A. You may be right. Now, I still would have to say that since this is underlined in red I assume I had this when I wrote that letter --

Q. Okay,

A. -- even though it's not listed in the letter, And it's, what, three pages long, four, something like that.

MR. SEIBEL: For the record, I brought the

original, or not the original, but the complete Fairview General Hospital chart with me today and we did spend some time before the deposition going over it,

MR. DELBAUM: Okay. And this Fairview General Hospital chart that you're referring to that you went over today is for which admission?

MR. SEIBEL: From I believe for every admission since October of 1987,

MR. DELBAUM: Okay.

MR. SEIBEL: You want to look? And I have this notebook here.

MR. DELBAUM: No, no, you don't have to show me.

BY MR. DELBAUM:

Q. I am going to ask you some questions about your report, so *why* don't I ask you to hold onto that for a moment, put all this back the way it was,

A. More of *my* red ink.

Q. Right. These are your handwritten notes?

A. Uh-huh.

Q. Is this just a draft of the --

A. That was a draft of the letter that you have typed in your possession, Thank you for not commenting on the penmanship,

Q. The thought --

MR. SEIBEL: He is not finished.

MR. FULTON: It's not over yet.

BY MR. DELBAUM:

Q. -- crossed my mind to ask you whether your secretary was really able to type this or whether *you* did it yourself, but it's none of my business, so I can't ask,

A. I will answer that, I put it on a word processor myself, it helps me organize my thoughts.

Q. I am going to hand this back to you so that you can refer to anything if you need to.

Preliminarily let me ask you before we get to the records, though, I believe you know Dr. Bob Norman, who will be the Plaintiff's expert in this case; is that correct?

A, I do.

Q. You serve on some committee with him?

A. I do.

Q. What committee is that?

A. Bob and I both attend a nursing home here in town and we are members of the Utilization Review Committee for that nursing home. So we *see* each other maybe, oh, twenty minutes every month or every other month or something like that,

Q. Are you familiar with his reputation in

addition to knowing him through this Utilization Review Committee?

A. Not really, The unfortunate thing there is that Bob attends at a different hospital than I do. He goes to Akron City Hospital, I go to Akron General, so I can't say that I know his medical reputation,

Q. What is your impression of his abilities based upon your contact with him at the Utilization Review Committee meetings?

MR. SEIBEL: Objection. Go ahead, Doc.

THE WITNESS: Based on what. I know of Bob's work in the nursing home where we both attend, I am not aware of any, any problems at all with his medical care,

BY MR. DELBAUM:

Q. To the best of your knowledge is he well respected by your peers in the community?

MR. SEIBEL: In the area of medicine?

BY MR. DELBAUM:

Q. Yes.

A. That's hard for me to answer simply because I am not, I am not on the same staff that Bob is on. So I -- 1 certainly can say nothing bad about Bob Norman.

Q. Okay, Do you have any reason to believe that he would have any bias in favor of patients who have

been injured by physicians as against physicians?

A. I have no --

MR. SEIBEL: Objection, Go ahead.

THE WITNESS: I have no reason to think that.

BY MR. DELBAUM:

Q. What do you know about his experience in caring for the elderly?

MR. SEIBEL: Objection.

THE WITNESS: Okay. Once again, my experience with Bob is limited to the fact that we both have patients in a nursing home, So obviously he takes care of patients in Valley View and I am aware of that.

I am also aware that he advertises himself as a geriatrician, I believe. And other than that, I can't comment for you. I don't even know where Bob's office is, frankly. I mean, it's not like we are close friends,

BY MR. DELBAUM:

Q. I understand. What do you mean by he advertises himself as a geriatrician? Where does he advertise?

A. I think if you were to look in the Phone Book, I think Bob would be listed as a geriatrician.

Q. Okay. So you mean that he claims that he is

a specialist in geriatric medicine?

A, No, I didn't say that. I said that he says that he is a geriatrician, I am not aware either whether Bob has his specialty boards in geriatrics.

Q. I didn't ask you whether you are aware of that, but only --

A. Oh.

Q. -- whether he claimed that he was a specialist in geriatric medicine?

a. No, I am -- okay, I don't, to my knowledge Bob doesn't call himself a specialist. Could we check the Phone Book? I could find out the answer to that.

Q. If you want to, it's not necessary to do it now.

A. Okay, all right. Do you understand the distinction I am trying to make?

Q. Yes, I do.,

A. Okay,

Q. In your experience with him at the same nursing home where you attend, you have not seen anything which would indicate to you that he does not have good judgment?

MR. SEICEL: Objection. Go ahead,

THE WITNESS: YOU are correct.

BY MR. DELBAUM:

Q. Have you written any articles or given any speeches on the subject of the care of the elderly?

A. No.

Q. Do you have a curriculum vitae available?

A. I may. I had to do one recently for the Summit County Mental Health Board, so I thought I knew where that was. It's not the kind of thing that I have very -- yes. I can get this copied for you if you would like.

Q. That would be helpful. In the meantime, if I could just look at it that would be fine,

A. Thank you,

MR. FULTON: If you copy it I would like an extra copy, if you don't mind.

THE WITNESS: Okay.

BY MR. DELBAUM:

Q. What courses have you taught as an instructor at any medical college?

A, I am an instructor with the Northeast Ohio Universities College of Medicine, and in that capacity every Wednesday afternoon that I am in town I teach family practice residents at the West Side Family Practice Center,

Q. You listed this in your curriculum vitae as 1976 *to* 1987. Was that because this was prepared in

1987?

A. That's probably -- that's an old one.

Q. So you are still doing this?

A. That's right,

Q. And what areas do you teach these students about?

A. Family medicine.

Q. Everything from birth to death?

A. That's right, Teaching on Wednesday afternoons involves occasional lectures, but mostly reviewing tapes and monitoring television, live encounters of resident physicians with patients and then discussing the cases with the residents.

Q. What percentage of the time that you spend teaching is spent on the subject of geriatric medicine?

A. I would guess fifteen percent, twenty percent, something in that neighborhood.

Q. Okay. Is that a pure guess or is that an estimate?

A. I am not sure I understand the distinction.

Q. Well, I suppose I could guess that it would take 20 hours to drive to Dallas from Cleveland, but never having done it I couldn't give you a reasonable estimate.

A. Oh, okay, I think that's a reasonable

estimate.

Q. Okay. What percentage of the time that you spend teaching these residents is on the subject of the care of decubitus ulcers?

A. That would be an infrequent topic in ambulatory medicine,

Q. This does not concern the care of patients in nursing homes, your teaching work?

A. That's correct, that's correct,

Q. Do you do any teaching that relates to the care of the elderly in nursing homes?

A. On the whole, no, The exception would be that if a resident in training had made nursing home rounds that day and I was the instructor on that afternoon and they came back to the center with any questions, I would be available to answer those questions. And that would be the only interaction I would have in teaching.

Q. Okay, And that happens to you --

A. That happens very infrequent,

Q. Okay. You have listed certain affiliations that you have in this document including Rockynol Retirement Home, Valley View Nursing Home, The Arbors at Fairlawn, As of the time that this curriculum vitae was prepared were those the only facilities for the elderly,

specifically for the elderly, with which you were affiliated?

A. At that time. I am currently also the Medical Director for Chambrel.

Q. What is that?

A. Another nursing home in the area.

Q. Spell that for me, please.

A. C-H-A-M- -- I am sorry, it's Windsong at Chambrel, W-I-N-Dsong at Chambrel, C-H-A-M-B-R-E-L. And I am also the Medical Director of the brand new nursing home called Copley Health Center, C-O-P-L-E-Y. That's since this thing was made out,

Q. Okay. That was going to be my next question. Are you still affiliated with Rockynol, Valley View and Arbors?

A. That's right.

Q. Okay. Are you medical director at all of those or --

A. Medical Director at the last two that I mentioned to you.

Q. Okay, The two that were not on this document?

A. Right.

Q. What kind of a facility is Windsong at Chambrel?

A. It's a 75 bed skilled nursing facility.

Q. And how long have you been Medical Director at Windsong?

A. Since it opened, roughly two years.

Q. Were you -- strike that. Did you have any patients at Windsong at Chambrel before -- well, strike that again. You said since it opened,

A. Right.

Q. So obviously you have many patients there. How about Copley Health Center, when did that open?

A. Um-m, 1 believe August, August or September of 1989. We have a grand total of I think eight patients there right now,

Q. And what type of facility is that?

A. Again, skilled nursing. We just received Medi-Care, Medicaid approval and got the place certified about two weeks ago finally.

Q. Of the patients at Windsong, approximately how many are under your care directly?

A. 25.

Q. As of the spring of 1988, approximately how many patients did you have at Rockynol?

A. Spring of '88?

Q. Yes.

A. Oh, my. I have no way of knowing back then.

Q. How many do you have now?
A. This is an estimate. Fifteen, Rockyknoll now
Q. Over the past two or three years has that varied substantially?
A. No.
Q. Or is that approximately what it's been?
A. That stays fairly constant.
Q. And how about: for Valley View, about how many do you have there now?
A. Twelve, I think, eighteen.
Q. Is that also a figure that stays roughly constant?
A. Yes, it does,
Q. Thank you, Are those both skilled nursing homes?
A. They are.
Q. And The Arbors at Fairlawn, what type of facility is that?
A. Again, a skilled nursing facility,
Q. About how many patients do you have there now?
A. Ten,
Q. Is that also roughly constant over the last two or three years?
A. That's right.

Q. When did you first start seeing patients in nursing homes?

A. Um-m, when I was a resident at Akron General, which would be 1973.

You mentioned in your CV that you have a minimum of 50 post graduate class hours per year since 2976 for prescribed credit, Does that continue to be true --

A. That's right,

Q. -- until today? Can you give me an estimate of the mix of those classes? What fields do they cover?

A. I think it would be fair to say that they cover all of the aspects of family medicine, except I have in recent years, for the last five or six years taken very few courses in obstetrics because I stopped doing obstetrics.

Q. Can you estimate the approximate percentage of those classes that deal. with geriatric medicine?

A. I would estimate twenty percent of the classes and lectures that I attend have to do with geriatric medicine.

Q. Can you recall when you last attended a class for -- or a lecture on the subject of the care of decubitus ulcers?

A, Can't say that I can recall when, no.

Q. I would like to have that marked as Exhibit 1 when we have a photocopying machine available.

A. Okay. Don't even want it updated?

Q. Well, you don't have an update, I take it.

A. No, I don't. This is the last time I printed something like that up, it was a couple years ago,

Q. Have you written any articles or given any speeches on the subject of medical/legal problems?

A. No, sir.

Q. Do you know Dr. Suntala?

A. No, I do not, other than to *see* his name, of course, in all. this literature.

Q. Sure, You have never had any personal contact with him?

A. No.

Q. Would you tell me about how you spend a typical day in your practice of medicine?

A, Late,

Q. Okay. Let's start in the morning. What do you do typically in the morning?

A. All right, I begin at 7:30 on the average making rounds at Akron General Medical Center. Very seldom do I have children to *see* at Children's, but if I do then I leave General and go to Children's, and then

try to make it out here to the office by 9 o'clock.

I see private patients between 9 and 12:30, break between 12:30 and 1:30, and then see patients between 1:30 and 5. And spend usually the next two hours trying to get the paperwork done that's on the desk here, and hopefully I am home by 7 or 8, average night.

Q. And is that true Monday through Saturday, Monday through Sunday, Monday through Friday?

A. Monday through Friday. And Saturday I am here, again, same time with rounds in the morning, but I start my office hours at 9:30 and work until noon.

MR. FULTOM: You should write that up immediately and send it to the young lawyers in our firm.

BY MR. DELBAUM:

Q. You didn't mention in how you spend your time when you get to the nursing homes to see the patients that you have in the nursing homes. Where does that fit in?

A. Okay. Wednesday afternoons, as I mentioned to you, I am teaching down at West Side, Every other Wednesday I leave the office, I don't come to the office at all on Wednesday, and I am at nursing homes every other Wednesday. I share that responsibility, my nursing home patients with Dr. Myers, who is here in the building

with me. And a lot of my nursing home rounds are also made after, after 7 or 8. You know, not usually that late, because many times they're in bed. After say 6:30 or so, if I get out of here I will go to the nursing home on an evening.

Q. Having nothing to do with any noise that's been in the room in the last couple of minutes ago, I am just not sure if I really followed your Wednesday schedules. And let me try to state it, tell me if I am wrong, That every other Wednesday you are at the nursing homes --

A. In the mornings,

Q. -- in the mornings.

A. Until 2 o'clock when I get to Akron General for teaching.

Q. Okay. And every other Wednesday other than the alternate Wednesday, you don't go to the nursing homes at all?

A. Unless I would go in the evening.

Q. Okay. Is there any difference in approach to the care of decubitus ulcers between osteopathic physicians and medical doctors?

A. I hope not.

Q. You are not aware of any?

A. No.

Q. Do you have any Board certifications?
A. I do.
Q. In what?
A. I am Board certified in family practice. I was first Board certified in 1976, and then recertified in 1982 and recertified in 1988.
Q. And by whom arc you certified?
A, The American Board of Family Practice.
Q. Can you estimate for me the total number of Alzheimer's disease patients that you have cared for at nursing homes in the past ten years?
A, I -- no, I can't, I can tell you that currently of those numbers that I gave you of nursing home patients, it may be a good estimate to say that 40 percent of them have Alzheimer's.
Q. But you are unable to estimate at all the total number of Alzheimer's disease patients that you have cared for in your practice of medicine?
A. I am -- that's right, Ten years is too much water over the dam.
Q. How about in the past five years?
A. I think my Alzheimer's must be affecting me. No, I really couldn't give you a reasonable guess on that either,
Q. Of the patients you're caring for now who

have Alzheimer's disease, can you estimate approximately how many have, or what percentage have some kind of cardiovascular disease?

A. Mo, I can't give you an estimate on that, I think the reason is that I don't necessarily equate one with the other, so I would really have to go through records to give you a reasonable estimate.

Q. Can you estimate for me what percentage of the Alzheimer's disease patients you are caring for now have Alzheimer's disease as advanced as Mr. Hofelich's was in the spring of 1988?

A. You know, I'm not sure I can answer that either, not having seen Mr. Hofelich or having any, any data that shows a mental status exam on him. I don't know how advanced his Alzheimer's was specifically at that time, so I think that's not, not something I should try to answer.

Q. In evaluating the care that Dr. Suntala gave to Wilbur Hofelich, you took into account the severity of his Alzheimer's disease, did you not?

A. Yes.

Q. What was your understanding of it for purposes of evaluating Dr. Suntala's care?

A. Okay, From what I could see from the records, certainly the man did have advanced Alzheimer's

disease. Mow, how I could compare that to other patients that I have, I don't know not having seen him myself.

Q. What were his symptoms or problems that led you to conclude that he had advanced Alzheimer's disease in the spring of 1988?

A. Okay. There were indications in the nurses records that he was confused, he was disoriented, he was sometimes belligerent, he was abusive, He had short-tern memory. For instance, they would try, germane to this case, they would try to position him and tell him to stay in the position, and obviously he wouldn't €or any length of time. Probably because he couldn't remember that he was supposed to stay in position.

He, there were indications in the chart -- well, I think that's enough.

Q. Okay. What percentage of the Alzheimer's disease patients that you are caring for now are confused, disoriented, sometimes belligerent or abusive and have short-term memory loss?

A. Well, I think that most of them are confused, disoriented and have short-term memory loss. The belligerence is a variable factor.

Q. Is the belligerence a sign of Alzheimer's disease being more advanced than the early stages?

A. Not necessarily.

Q. So there is nothing about Mr. Hofelich's mental status, as you were aware of it when you were evaluating the care, that would indicate to you whether his Alzheimer's disease was more or less advanced than most of the patients you care for?

A. Once again I think that's hard for me to answer not having seen or examined that man myself. I really would hesitate to compare him with patients whom I have seen.

Q. Well, my question was whether there was anything you knew about him to make it perhaps -- let me withdraw that, perhaps it wasn't clear enough,

The question was whether you knew anything about him from the records and Dr. Suntala's deposition and the other materials you had, which indicated to you that his disease was more advanced than the Alzheimer's disease of most of the patients you care for?

A. Anything to indicate it was more advanced? I really -- than most of the patients that I care for. I think that's a fair statement to make,

Q. That -- I am sorry?

A. Your question was, is there anything from my reading the records that would make me think that his Alzheimer's was not any more advanced than most of the Alzheimer's patients that I have taken care of?

Q. No, actually it was that question, but without the "not". Was there anything to --

A. Make me think that it was more advanced?

Q. Right. Let me say it again, because we have gone around several times and I don't want the question to be unclear. Was there anything in the records or the depositions that you read which led you to conclude that his Alzheimer's disease, Mr. Hofelich Alzheimer's disease was more advanced than the Alzheimer's disease of most of the patients that you care for?

A. That is correct, there was nothing in those records.

Q. Okay. Of the Alzheimer's disease patients that you care for yourself currently, do any of them have decubitus ulcers which are more than an inch in diameter?

A. No.

Q. Have you had Alzheimer's disease patients who are under your care from the time they enter the nursing home until the time they left, for whatever reason, who have had decubitus ulcers which grew to more than an inch in diameter?

A. I have.

Q. Okay. About haw many?

A. We are asking again over a period of ten' years?

Q. Yes.

A. This is difficult to substantiate, but I would say maybe a half dozen in that many years.

Q. And of those, how many had decubitus ulcers that were more than two inches in diameter on the surface?

A. Golly. I can think of perhaps two.

Q. Can you recall what other illnesses those individuals, that we have now narrowed down to approximately two, had other than their Alzheimer's disease?

A. No. The first one I can't, it was too many years ago. The more recent one, she had cerebral vascular disease, stroke and her Alzheimer's and decubitus, which was complicated by mocking an osteamyelitis.

Q. Where was this decubitus that was larger than two inches for this lady?

a. On a foot.

Q. On her ankle or some other part of the foot?

A. I believe it did start on the ankle.

Q. What efforts had you made while she was your patient to avoid having it get larger?

A. Removal of any pressure to the area is I think the most important thing always, treatment with

topical antibiotics is an iffy sort of thing whether it helps, but it's something that we always do.

Q. Excuse me, Doctor. I wasn't asking you about what you think the treatment should be or the general standard and so forth --

A. All right.

Q. -- but rather what you did for this particular patient,

A. Okay. And eventually she was treated with intramuscular antibiotics.

Q. What, if anything, did you do to monitor the stake of her nutrition during the period of time the decubitus was developing?

A, Very little, because the family had already decided that they did not want me to use any internal feeding methods, and so monitoring her nutrition would have been an exercise in futility, and I think unnecessarily costly,

Q. You can monitor nutrition through blood tests, also, correct?

A, That's correct,

Q. Was there any reason not to do that?

A. Right, because I wouldn't have had any way to correct it.

Q. I see,

A. Family did not want her fed by a tube, they didn't want IVs, so why should I, in her case, find out something that I can't correct?

Q. Was she eating as much as she possibly could?

A, No, not at all.

Q. Oh, she wasn't eating at all?

A. Very little.

Q. Would you agree with me, based on your own experience, that. decubitus ulcers larger than two inches are rare in the average nursing home?

A. I think rare is a proper term.

Q. Okay, Having reviewed the nursing home charts for the care of'Wilbur Hofelich at Manor Care of North Olmstead and Dr. Suntala's deposition, are you able to determine with hindsight whether there is anything that could have been done to prevent tho deterioration of Wilbur Hofelich's decubitus ulcer that wasn't done?

MR. SEIBEL: Objection.

THE WITNESS: No, I'm not. Even with Monday morning quarterbacking and hindsight, I feel as though his care was proper.

BY MR. DELBAUM:

Q. That wasn't my question,

A. I feel as though there was nothing that

could have been done to prevent the course of events.

Q. Had you thought about that question before I asked it of you just now, or was that something you hadn't thought about previously?

A. I think that was a question that I had to put in my mind when I picked up this chart, You know, what went wrong here and what could have been prevented? So surely I had thought of that question as I read through those charts.

Q. Fine. Frankly I assumed you had, and what I was going to ask you is can you tell me what some of the possibilities were that you run through your mind and decided would not have helped here?

A. Okay. As that question was in my mind in reading through the charts, I would look at things that were done for him in terms of efforts made to keep him off of his decubitus area, efforts made to try to keep him dry, The indication in the record that he was eating, and in fact his wife was feeding him. I looked at the reports that were called to Dr. Suntala from time to time and the timeliness of his response. And I looked at the number of visits that Dr. Suntala had made, and 1 really found nothing objectionable.

Q. Do you have any basis on which to conclude that the nursing home could not have kept him off his

back more than they did?

MR. PULTON: What was that question? Wait a minute, read that question back, please.

(The previous question was read back.)

BY MR. DELBAUN:

Q. You can answer that.

MR. FULTON': That's kind of like a double negative almost, but it isn't -- go ahead.

THE WITNESS: Shall we rephrase it and say do I have any basis to conclude that the nursing home -- you are right, it is a double negative,,

BY MR. DELBAUM:

Q. We can phrase it differently. Do you have any basis on which to conclude that the nursing home kept him off his back to the maximum extent that was feasible?

A. Okay. Yes, sir. I think that there is reasonable documentation that those nurses were trying and had their plan of care written out to keep him on a position other than on his back. They had wedged pillows in, for instance, to try to keep him on his side. There was evidence that they tied a hand across the bed to try to keep him up on his side.

There is even notations that they had him in his -- out of the bed and in a chair, which would have put some of the pressure on his lower quads instead of on

his coccygeal area. And as you're aware, the family didn't want him out of bed. There is some notes in there that the wife evidently wanted him taken from the chair and put back in bed quite frequently,

Q. What is the basis for your understanding that a wedged cushion was used as much as it could be?

A. Just seeing that it was mentioned in the nursing notes as part of their care.

Q. Was it documented that it was used throughout the several months before Mr. Hofelich went to the hospital in May of 1988?

A. I can't answer that. I don't know what times it was, it was specifically mentioned.

happened in your practice?

A. Estimation, three or four times in ten years,

Q. And what were the signs or symptoms that led you to conclude that a surgical consult was appropriate?

A, When the amount of the necrotic tissue just obviously becomes overbearing to the point where it's

obvious that medical debridement is not going to do it, elase and wet to dry dressings and things like that.

And if you realize that, you know, over a period of time you are not getting anywhere with that, then I guess it's time to throw in the towel and ask a general surgeon to take some of the dead tissue away.

Q. Row long do you consider it appropriate to try the elase or other non-surgical. debridement techniques before deciding to throw in the towel?

A. I think that's just an individual judgment that you would have to make when you see that things are getting out of hand or that you're not -- that you're not getting anywhere. And I don't think there is any limit of time that you could set on that, because it varies so widely in terms of how fast they develop in different people.

Q. Assume that you are using elase and the decubitus doesn't respond by improving, but rather continues to deteriorate over a period of three or four days,

A. Uh-huh.

Q. Would you feel that was enough time to have tried the elase before deciding that a surgical consultation was appropriate?

MR. SEIBEL: Wait. Are you saying no

improvement or deterioration?

MR. DELBAUM: Deterioration.

MR. SEIBEL: Okay.

THE WITNESS: No, sir. I can't imagine that three or four days is enough to make any rapid decisions. These things are *so* slow in developing and so slow in healing that I would be hesitant to say that three or four days, or even one OK two weeks, would make a whole lot of difference one way or the other in a decubitus ulcer.

BY MR. DELBAUM:

Q. So you would continue to try elase for as long as two weeks, even though the decubitus ulcer continued to get worse while you were using the elase; is that correct?

A. You're asking me to put a time on something that when I really, really don't see the actual situation, and that's difficult. But I see no problem with two weeks, if that's your question.

As an example, Mr. Hofelich took like eight months to heal after his ulcer was debrided, I believe, if I read the records correctly.

Q. Which records did you read that led you to conclude that?

A. The nursing home record. I mean, after his

surgery in May of '88, that area wasn't healed over until about the spring of the next year.

Q. Is that based on his Fairview General chart excerpt from February of '89?

A. No, no, that would be the nursing home records,

Q. Well, the nursing home records only go to February -- I am sorry, the nursing home records only go to my of '88.

MR. SEIBEL: You are forgetting that Dr. Payton was provided with the deposition of Dr. Santiago. I believe that is reflected in Dr. Santiago's deposition,

BY MR. DELBAUM:

Q. Is that what you are referring to, Dr. Santiago's deposition?

A. I imagine that's where it came from. My point in bringing that up is these are slow to form, slow to heal, Maybe, you know, no way that we should put a time limit on an individual ulcer.

Q. Okay. In your practice do you have any general procedure that you follow with respect to how frequently you visit a patient who has a decubitus ulcer that is increasing in size and is purulent?

A. I would say it's fair to say that I see my nursing home patients every, roughly, 28 Lo 30 days

regardless of their condition. If their condition becomes acute and it's something that needs more frequent visits than that, normally they belong in an acute care hospital.

As -- just to give you an aside on that, if we visit nursing home patients that are on Medicaid more often than every 28 days we have to write a letter of explanation to the government begging permission to charge for having seen the patients more frequently than 28 days and explain why. Quite frankly, it isn't worth it.

Q. It isn't worth it to write the letter or --

A. It's more --

Q. -- or isn't worth it to make the visit?

A. It isn't worth it to write the letter, to do all the government paperwork involved.

Q. If I understood what you said correctly, and please tell me if I didn't, you don't see patients in nursing homes more frequently than once every 28 to 30 days?

A. On the, on the average, that's correct,

Q. And if they have an acute condition which requires, in the nursing homes you -- strike that. If they have an acute condition which seems to require the attention of a physician, your view is that they belong

in a hospital?

A. In many cases. There are exceptions when I will make a special trip to the nursing home.

Q. Under what circumstances do you make a special trip?

A. Oh, my. When the nurse hears pulmonary noises that she thinks are indicative of pneumonia. I can't frankly ever -- I don't think that I have ever made a special trip to go see an ulcer, if that's getting down to what you're really asking me,

Q. Can you tell me what tunneling is in connection with the decubitus ulcer?

A. I may have mentioned that in the letter. I think tunneling is a disease process where an ulcer may appear on the surface to be at a certain stage of decay, and yet tunneled underneath that surface appearance there may be much more decay than is visible on top.

Q. How can you tell if tunneling is going on underneath necrotic tissue?

A. Monday morning quarterbacking. Again, you find out after the fact when the good tissue on top that covers up the tunneling finally rots and decays and opens up, and then you find out that the things are worse underneath.

Q. Are there any indications that tunneling is

probably going on that a physician can look for when examining decubitus ulcer that has a necrotic top?

A. I can think of none other than if the area became very fluctuant, you may guess it then, If you press on it and you felt a great area of fluctuancc underneath, or liquid, you may get the idea then. But other than that, I can't think of anything from physical examination that would tell you that tunneling is going on.

Q. Is assessing the possibility of fluctuance in connection with the decubitus ulcer something that R.N.s are competent to do generally, in your experience?

A. I would think so.

Q. How about L.P.N.s?

A. It just depends. It would depends on their training.

Q. On how skilled --

A. That's right,

Q. -- and how well. trained they were? And the same -- strike that,

How about nurses aids? You wouldn't expect they would be competent to do that, would you?

A, No, I wouldn't. Nurses aids require very little medical training, if any,

Q. If I understand your conclusion in your

report correctly, your opinion is that Dr. Suntala's care of Wilbur Hofelich met the standard of care for physicians treating patients in nursing homes: is that correct?

A. I believe so, yes.

Q. What is your understanding of the concept of standard of care in your evaluation?

A. The concept of standard of care would mean that a physician performs his medical duties in a mannex that is comparable to his peers in that community.

Q. After you reviewed the depositions of Dr. Suntala and so forth as listed in your report, did you ask for the opportunity to review any of the records from the Fairview General Hospital before Mr. Hofelich entered Manor Care in 1987 and in May of 1988 when he went to Fairview General for surgery?

A. Yes, I did that today, He brought them with him and I looked through them.

Q. You had not done that before today?

A. That's correct,

Q. Was that because you didn't -- is the reason you hadn't asked for them before today -- strike that. Did you ask that they be brought today or was this just something that was done?

a. I think it's something that was just done.

I may have mentioned in a phone conversation that it would be nice to see these records, I am not aware.

Q. Okay. Having now reviewed them --

A. Not that thoroughly, mind you.

Q. Okay, Well, let's start with the time you were preparing the report, you apparently did not feel that the information in the Fairview General Hospital charts from 1987 and from May of 1988 would help you in determining whether Dr. Suntala had treated this decubitus ulcer properly; is that correct?

A. No, that's not. I simply used the information that was given me to write the report, I didn't have any opinion as to whether other information would have been beneficial or not.

Q. Having now had a chance to look, albeit briefly, at the Fairview General Hospital chart, is there any information in those charts which you believe supports the opinions that you've given in your report or opinions that you plan to give at trial?

A. Yes. As a matter of fact, what: I was particularly looking for in Fairview General was whether or not Mr. Hofelich had proteinuria, It's been surmised that malnutrition was part of his problem with the decubitus ulcer, and the question is how does he become hypoalbumin, how does he -- off the record.

(Off the record,)

THE WITNESS: I was particularly interested in those records to find out whether he was losing protein through his urine. And yes, in fact he was. He showed anywhere between trace and two plus urine protein, We also showed an elevated creatinine,

Now, if you combined those two things, you can say with a fair degree of certainty that this fellow had a nephropathy going on, And if indeed he had a nephropathy, the protein that they were putting in through his mouth was getting passed on out through the urine, which helps explain why his serum protein and albumin were low on many occasions,

So even though his wife was feeding him and he was eating as well as he should have, that gives a logical explanation for why his serum protein and albumin were low,

BY MR. DELBAUM:

Q. What is the range of normal for protein in the urine?

A, There should be none.

Q. Do you know what the range of abnormal protein in the urine is with the protein nephropathy?

A. Any, any protein in the urine is abnormal.

Q. Does the amount of protein in the urine, the

numbers that you were using initially, trace to two plus --

A. Oh.

Q. -- indicate how bad the nephropathy is?

A. Mot really.

MR. SEIBEL: Didn't go in that order, by the way.

MR. DELBAUM: I beg your pardon?

MR. SEIBEL: It didn't go in that order. *You* said trace to two plus, it was -- it didn't necessarily -- the first reading wasn't trace and the last reading wasn't two plus,

MR. DELBAUM: Yeah, I understand.

BY MR. DELBAUM:

Q. What you said was --

MR. SEIBEL: Okay.

BY MR. DELBAUM:

Q. -- they vary between trace and two plus.

A. Right.

Q. That's all I meant, If it didn't come out that way, that's the way I meant it. To answer my question --

A. I cam sorry.

Q. You have forgotten what it is?

a. Yeah,

Q. Um-m, well, so have I,

MR. DELBAUM: Would you read it back, please?

(The previous question was read back,)

THE WITNESS: No, that is not a definitive figure. It's fair to say that one plus protein is worse than trace, and it's fair to say that two plus is worse than one plus, but a more definitive thing would be to have a 24 hour urine collection for total protein.

BY MR. DELBAUM:

Q. Okay. Without that, is there any way to estimate about how much protein he was losing in his urine?

A. It would be an absolutely that, an estimate, through the one plus, trace, two plus method.

Q. Okay. Do you have an estimate for how much protein he was using -- strike that. Do you have an estimate for how much protein he was losing --

A. Losing.

Q. -- through his urine in Play of 1988?

A, No, sir, I do not,

Q. So there is no way for you to conclude that the nephropathy which you believe he had was having any significant impact on his ability to retain the protein that he was eating?

A. I think it would be a significant impact.
Q. And how do you define significant?
A. But, well, only because it was present and it should not be present at all in the urine, So any protein loss is significant,
Q. Well, I understand that. But it might mean that there was a one percent, he was losing one percent of the protein that he was eating through his urine; isn't that correct?
A. Let's *see*, You're right, I have no way of knowing from the total amount of protein that he ate how much was passing through the urine from the tests that I saw.
Q. Okay. If Wilbur Hofelich had been given additional protein supplements in May of 1988, April of 1988 while he was still at the nursing home, would he have retained some portion of those additional supplements despite his nephropathy, or would all the supplement have gone out in his urine?
A. It, some percentage of it certainly would have still gone out in the urine.
Q. So to some extent his protein nephropathy was treatable by giving him additional protein supplements?
A. No, that doesn't -- giving additional

protein doesn't help the kidneys. They're still going to, they're still going to lose protein just as fast and just as much, or even probably more. If he gets more protein orally he is probably just going to urinate more of it out.

Q. Okay. I misspoke in my question by asking about treating the nephropathy.

A. Okay.,

Q. What I should have said is his malnutrition, to the extent that he didn't have adequate protein in his bodily systems, in his blood, for example --

A, Uh-huh.

Q. -- could have been treated to a degree at least by giving him additional protein supplements despite the fact that he had a nephropathy?

A* I -- no, that's my point. I think that the nephropathy may have made it impossible to increase his serum protein, no matter how much they gave him.

Q. You say the nephropathy may have made it --

A, Let's even, let's call it the presumed nephropathy just so we don't get hung up here. My presumption is he has a nephropathy because of the elevated creatinine and the protein in the urine.

Q. Okay. And then you said that the presumed nephropathy may have made it impossible for him to retain

additional protein even if he had been given protein supplements?

A. Yes.

Q. Why is that?

a. Well, because there is a certain threshold above which protein simply spills out in the kidneys, and once that threshold is reached in the serum of the blood, everything else just, if you will, tumbles over the dam and is urinated out.

Q. Okay. Now, you have quite correctly qualified your statement as indicating that it's a presumed nephropathy we have been talking about.

A. (Witness nodding head up and down.)

Q. And you are shaking your head yes.

A" That's right, yes, I am.

Q. What is the probability that he had a nephropathy, in your opinion?

A. Very high probability,

Q. Can you quantify that?

A. Well ---

MR. SEIBEL: All you need to do, Doctor, is say whether it's greater than 50 percent to make it a probability.

BY MR. DELBAUM:

Q. That wasn't my question. My question was

whether you can quantify it?

A. I would, I would say it's a very reasonable assumption that he had a protein losing nephropathy based on the data that I see in that chart.

Q. You refer in your report to, at page one, paragraph two, to not placing the blame on his wife for less than maximal feeding among other things, Do you see where I am referring to?

A. Uh-huh.

MR. FULTON: That isn't a complete reading of it, Charlie.

MR. DELBAUM: Yes, I realize that, I am just referring to that one particular point.

BY MR. DELBAUM:

Q. What leads you to conclude that Mrs. Bofelich was responsible in any way for his less than maximal feeding?

A. Let's read that; whole thing. I am not at all concluding that she is responsible for that.

Q. Well, then let me just ask you whether you feel that she bears any responsibility?

A. Of course not,

Q. Okay,

A. No. I am using that as an example to say that it makes no more sense to blame the wife for his

illness than it makes sense to blame the physician for it.

Q. Well, I am trying to find out whether in your understanding of the facts Mrs. Hofelich was responsible, even though not blameworthy, but responsible for his less than maximal feeding?

FIR. SEIBEL: I can assure you we do not make that claim.

THE WITNESS: That's right,

BY MR. DELBAUM:

Q. Okay. Kou do have an understanding that she was responsible for ordering him out of a chair?

A. Yes.

Q. Okay. How often is it your understanding that she ordered him out of the chair?

A. I saw it mentioned more than once. I, you know, and if she actually told the personnel that, I assume that that, that the personnel would realize that that was a standing wish of hers.

Q. But you don't know that for a fact?

A. I don't know that,

Q. Whose decision is it whether a Foley catheter should be removed or not?

A. You need an order from a physician for removal, The only possible -- well, the only possible

exception, and that is still covered by physician if they are standing orders in the nursing home, to remove a catheter or bladder drain if possible, hut even those standing orders are signed by the physician.

Q. You refer in your report to Mr. Hofelich having arterial sclerotic disease of his arteries as demonstrated by a stroke. I am looking at the bottom of page one, if you want to review that.

A. Okay.

Q. Okay. And you explain that a stroke indicates that, you say an artery blocked off blood supply to the brain, but I assume what you mean is something blocked off blood supply which an artery would normally supply to the brain,

A. Uh-huh.

Q. Correct?

A, That's correct.

Q. Do you have any information which indicates to you the extent: of the blockage of the artery to the brain which resulted in the stroke?

A. No.

Q. What do you know about the stroke'?

A. Only that he had one,

Q. Do you know when?

A. I would have to review the records to tell

you when.

Q. Do you know what damage was done as a result of the stroke?

A. He was left, as I recall, hemiparetic, Again, I would have to review those.

Q. Please do. I am --

MR. SEIBEL: You mean you want him to tell you what is in the records?

MR. DELBAUM: I want him to tell me what his understanding of what is in the records is, yes,

THE WITNESS: It may take awhile. I think --

MR. SEIBEL: You are wasting your time,

THE WITNESS: Was his stroke in the fall, do you know? I mean, I don't even know where to start looking.

MR. SEIBEL: I will try to find it for you, Doctor.

BY MR. DELBAUM:

Q. Okay. While Mr. Seibel is looking for you, that's fine if he finds it. What if anything do you know about the extent of the damage to his heart muscle from the heart attack he had had?

A. Once again, just from the records, I took note that he had had history of myocardial infarction.

Q. Okay, You don't know the extent of the damage to the heart muscle?

A. No, I don't,

Q. You don't know the extent of the blockage of the artery to the heart?

A. No,

Q. You state that in all probability he had arterial sclerosis in every artery of his body. Can you quantify the probability that he had arterial sclerosis in every artery of his body?

A. I think that it's fair to say that if he has demonstrated arterial sclerosis in two distinct separate parts of the body, the head and the heart, that it's fair to think that other arteries of his body would be arterial sclerotic in all probability.

MR. SEIBEL: Doctor, I am sorry, I have found the records that indicate when he had the stroke, Here's the discharge summary. I believe it's on the second page towards the middle,

MR. DELBAUM: Which discharge summary is that from Fairview General. Hospital? When?

MR. SEIBEL: 2/14/89 admission, 3/24/89 discharge. It happened during this hospitalization,

THE WITNESS: Okay. Well, in this, I am just. reading, ischemic heart disease, unstable angina. I

still haven't found a date for the stroke.

BY MR. DELBAUM:

Q. Let's assume that Mr. Seibel is correct, that the stroke occurred while he was in the hospital in 1989.

A. He had a stroke before that.

Q. That was going to be my question. You believe he had a stroke before the time period we are looking at, the spring of 1988?

A, Yes, I believe so, Let me see if this red paper helps me. Is this very important to you that. we find this?

Q. Why don't we leave this for the end, see if we can come back to it,

A, Okay.

Q. Are you able to assess the extent of the impairment of his circulation as a result of the arterial sclerosis that he suffered from?

A. Am I able to assess the extent of his impairment --

Q. Yes,

A, -- due to arterial sclerosis?

Q. Yes.

A, Other than to tell you that the man had a very poor quality of life, I mean, he was a bedridden

patient,

Q. Well, my question was, which maybe I didn't make clear enough, is are you able to assess whether he had a ten percent impairment of his circulation, a twenty percent, a fifty percent, fifty-seven percent?

A, No, no, I would not.

Q. By the way, on the subject of the nephropathy we were talking about earlier, do you have an opinion as to whether the nephropathy, if indeed he had one, would or would not have been demonstrated on a blood test if one had been done in April. of 1988?

A. In April of '88. Once again, the blood tests that I cited to you that I was looking at were creatinines and urine tests for protein.

Q. Right.

A. Okay.

Q. Which is part of the standard --

A. What you are asking me, was a creatinine done in April *of* '88? I don't know.

Q. No, no, those are part of a standard series of -- those are part of a standard series of urinalysis tests?

A. Right,

&a I should have asked you if urine -- urinalysis had been done in April of '88, would that

probably have shown the protein nephropathy?

A. It very well may have, yes.

Q. And what treatment is available for protein nephropathy?

a. I am not sure that I am qualified to answer. I don't get into treating nephropathies, I refer them over, My experience has been most of the time the nephrologists say this is a progressive disease and there is no treatment, That's been my experience.

Q. Have they indicated to you how quickly it progresses?

A. It varies with the individuals and what is causing the nephropathy.

Q. Did you look at any of the later hospitalizations to determine whether Mr. Hofelich had protein in his urine in, for example, February of 1989 when he was in the hospital?

A. Yes, I did. And I believe --

Q. Okay. You don't have to do it again,

A. Okay.

Q. I just wanted to know,

A. I believe he did have -- continue to show protein,

Q. You mentioned in your report that among the contributing factors to his being susceptible to the

formation of a decubitus ulcer in the coccyx area was his incontinence of urine and stool.

A. Uh-huh,

Q. Whose responsibility was it to deal with the problems of incontinence of urine and stool that he had?

A, I am sure that falls into the category of the nurses aids, the L.P.N.s and the R.N.s that you have mentioned previously.

Q. Dr. Suntala also ordered certain dressings that would be designed to keep any urine or stool out of the decubitus ulcer area; isn't that correct?

A. Easier said than done, You can order those dressings, but if -- you can't make them water tight, certainly.

Q. Do you have an opinion as to what the cause of the rigidity that has been described for Mr. Hofelich was?

A. His rigidity?

Q. Yes,

A, His rigidity may be attributable to his Alzheimer's disease and his lack of normal motion, being a bedridden patient.

Q. Is that your opinion, that it's attributable to --

A. That would be my opinion, if you are asking

it.

Q. Yes. It's rare, is it not, to have Alzheimer's disease patients at this stage of the disease who have rigidity because of the Alzheimer's; isn't that a fact?

A. I am not aware of that.

Q. About how many of the Alzheimer's disease patients that you are taking care of have rigidity?

a. Rigidity?

MR. SEIBEL: I apologize for not having you do a demographic study of your patients before this deposition,

THE WITNESS: Yeah, I know. I could probably find four to six of them in nursing homes currently that have some degree of rigidity.

BY MR. DELBAUM:

Q. And no other cause €or it other than Alzheimer's disease?

A. No other presumed cause than Alzheimer's.

Q. You mentioned that another possible contributing factor here was previous low back surgeries, I am sorry, previous spinal surgeries, And you raised the question as to whether one of them might have been a low back area,

How close to the decubitus area would a

scar from previous surgery have to be to interfere with the blood circulation to that area?

A. I still know no more about that supposition than I did when I wrote the letter, but if he had lumbar spinal surgery, an incision in the lumbar area would cross nerves that innervate the coccygeal area in the, in the skin. In fact --

Q. To what extent --

A. -- it's a common complaint of patients that have lumbar diskectomies that they can't feel their tailbones any more, or they can't feel their coccyx area after the surgery.

Q. My question was to what extent -- I am sorry, my question was to -- strike that. Let me try again.

My question was how close would the scar from the surgery have to be to compromise the circulation to the area, not to interfere with the nerve conduction in the area,

A. Oh, to compromise the circulation, I don't think -- hum, Circulation and innervation are so, go -- circulation and innervation are so closely entwined that I think that the incision would affect both equally. And I stand by saying that an incision in the lower lumbar area, if that's what he had, could have contributed to

poor circulation and innervation of the coccygeal area,

Q. How would you determine --

A. And you are asking how close that is.

Q. Right.

A. That's a distance of maybe three inches.

Q. And how would you determine whether this surgery in that area probably had or had not compromised the circulation in Mr. Hofelich's particular instance?

A. I don't think there is a way of determining whether it did or did not in his particular instance.

Q. Okay. You agree with me that black necrosis should always be debrided in a decubitus ulcer?

A. Um-m, no.

Q. Under what circumstances would it not be appropriate to debride black necrosis in a decubitus ulcer?

A. I have seen, I have seen patients with black gangrene, dry gangrene that surgeons simply refuse to debride as long as the gangrene is dry,

Q. In a decubitus ulcer?

A. Right, It's, I mean, in ulcers that start in a decubitus position, usually on the feet, and then if it's dry, surgeons on occasion will not debride it,

Q. Have you discussed with them the reasons that they choose not to debride it?

A. If, if the -- this is probably not germane to this patient.

Q. Okay,

A. Mr. Hofelich.

Q. Because this wasn't dry?

A. That's right.

Q. Okay. So let's limit it and make it simpler. Should black necrosis, which is not dry, always be debrided?

A. Either medically OK surgery -- surgically, I think *so*.

Q. Okay, Would you agree with me that surgical debridement is the most effective way?

A. No.

Q. When you order elase, which is a treatment that you prescribe; is that correct?

A, I have,

Q. Do you give any instructions to the nursing staff as to how to use the elase?

A. No, That, those instructions are usually in nursing manuals in the nursing home.

Q. What is your understanding of the way it's suppose to be used?

A. It's simply applied and changed on a regular basis. And hopefully the necrotic ulcer adheres to the

dressing that is put over the elase and is taken off with each dressing change, It's a very slow method of debriding the black eschar that you're talking about as opposed to a scalpel, which would debride it rapidly.

Q. Your understanding of the treatment is that the elase ointment is spread over the decubitus ulcer and a dressing is then put on top of the elase ointment and at some point the dressing is taken off and the hope is that some of the --

A, That's my understanding,

Q. -- necrotic tissue will come off with the dressing?

A. Right,

Q. Is there anything else that's done as part of that treatment, in your understanding?

A. There very well may be, but it's in the realm of nursing and I wouldn't know the exact methods that are used.

Q. When you're using elase to debride necrosis, how can you tell if it's working?

A. I suppose it would be getting smaller, the black area, the eschar that you're talking about.

Q. Should the physician in charge of the patient with a decubitus ulcer assess whether dead tissue has been removed before starting DuoDerm for the wound?

A. Should the physician assess whether dead tissue is present before using DuoDerm?

Q. Right.

A. I can't think of why.

Q. Have you had a chance to review or gain any knowledge about the treatment that Dr. Suntala ordered in Fairview General Hospital in May of 1988?

A. Probably not, since the records that were provided to me were primarily those nursing home records,

Q- Okay, Are you going to offer any opinions about the care that he rendered at Fairview General Hospital in May of 1988?

A. How could I do that if I haven't seen them?

Q. Okay. And you haven't seen the records at St. Augustine Manor, you have only seen Dr. Santiago's testimony; is that right?

A. That's right.

Q. What is your understanding -- strike that.

A. May I ask, I see I am getting close to missing my 4 o'clock meeting, is there any idea how much longer you need?

Q. I am sure it's going to be at least another half hour minimum, maybe longer. Nobody told me before we came down here today that we had two hours to do this,

A. All right. Let me make a phone call.

(A short recess was taken.)

BY MR. DELBAUM:

Q. There was mention I think in your earlier testimony about the use of a ring when Mr. Hofelich was up in a chair.

MR. SEIBEL: I don't think he said anything about a ring. We just talked about the fact that he was up in a chair.

MR. DELBAUM: Okay. I am sorry if there was nothing about a ring.

BY MR. DELBAUM:

Q. Do you recall reading something about a rubber ring being used?

A. A doughnut you mean?

Q. Yes, a doughnut.

A, Yes, uh-huh,

Q. Okay. What is your opinion as to the appropriateness of the use of a doughnut when Mr. Hofelich was up in a chair in Manor Care?

A. Either up in a chair or with or without a doughnut would have been an improvement over lying with direct pressure on the decubitus area,

Q. Are there any disadvantages to using a doughnut for a patient with a decubitus on his coccyx?

A. No. As a matter of fact, that should help

remove pressure from the area. The disadvantage is that he may not have kept it in the right place and that that would be very difficult for a man like this.

Q. Would --

A. You have to keep the doughnut centered.

Q. -- Wilbur Hofelich have qualified for inclusion in the skilled unit at Manor Care?

A. Would he have qualified for skilled care?

Q. As of April and May of 1988.

A, You know, I am not sure that I can answer that, Well, it's my understanding that Medi-Care does not look upon decubitus ulcers many times as a requirement for skilled care, but that's best asked of somebody that's more familiar with the Medi-Care rules than me.

Q. Were --

A. They change, they change drastically. As of the first of January with the comprehensive Medi-Care law, that then has since been rescinded, that there were just changes in what Medi-Care thought was skilled and what wasn't skilled,

Q. Are there services that would have been available to him in the skilled unit that weren't available to him on the Alzheimer's unit of the nursing home?

A. I can't answer that because I don't know what services are available in that nursing home.

Q. Have you ever had occasion to order any special beds of any kind for any patients you have had with decubitus ulcers?

A. Um-m, yes.

Q. Under what --

A, Hospitalized patients, I have never seen these Clinetron or other types of beds, Mediscus beds used in nursing homes, although they may be available.

Q. You don't know whether they are OK they're not?

A. Oh, for a price anything is, and I believe these beds run something like $80 a day or $100 a day or something like that. So I know they are available to be rented in anyplace. You can get them for your home if you wanted.

Q. Is it your understanding that there were periods of time when Mr. Hofelich's mental status was clear in the spring of 1988?

A. To the best of my recollection from those records, no, not in the spring of '88. But I would have to qualify that and say I would have to go back and look again,

Q. Okay. What is your recollection of his

ability to communicate his desires in the spring of 1988?

A. Very poor.

Q. What is your recollection of his ability to communicate his feelings in the spring of 1988?

A. Again, very poor. I think I recall times when the nurses indicated that his wife thought that she could communicate what those feelings were and those notes were entered that way. The wife felt as though he felt that, you know, that sort of thing.

Q. What is your understanding of his periods of lucidity, if any, in 1989?

A. Again, I would have to go back to the record to tell you specific dates of when he was lucid and when he wasn't.

Q. Okay.

A. My understanding is he was not lucid in 1989 to any great extent.

Q. Alzheimer's is a progressive disease; is that correct?

A. That's right.

Q. So you would expect his mental status to be worse in 1989 than it was in 1988; is that a fair statement?

A. That's a fair statement on the basis of Alzheimer's.

Q. Right. Is there something else that you think might have changed his mental status between '88 and '89?

A. There are other things that could have, I did not look at the record to find those things, but certainly there are many factors that would change his mental status other than Alzheimer's.

Q. What are some of those factors?

A. His cerebral vascular disease that we have spoke of, medications could change one's mental status, general physical nutritional well being could change the mental status, three examples.

&- Have you done any surgical debridements of decubitus ulcers yourself?

A. No, sir.

Q. Have you been present when they have been done by surgeons?

A. No, I have not.

Q. Have you ever taken care of a patient at a nursing home who had Alzheimer's who wasn't paralyzed, but who didn't respond to pain?

a. Have I ever taken care of a patient who had Alzheimer's who was not paralyzed but didn't respond to pain?

Q. Yes,

A. Oh, yes.

Q. What was the state of their mental condition for those patients, or is there no way to characterize that?

A* What is the state of their -- just vegetating I guess is the best word; is that what you are --

Q. Yes,

A. Vegetating state.

Q. So you have had Alzheimer's disease patients who were essentially in a vegetative state who did not respond to pain?

a. Uh-huh.

Q. Yes?

A. That's correct.

Q. Have you had any who were -- any Alzheimer's patients who were not in a vegetative state who didn't respond to pain?

A, No.

Q. Okay. In your opinion was Wilbur Hofelich in a vegetative state in April and May of 1988?

A. No.

Q. Do you have any reason to believe that Wilbur Hofelich was unable to feel pain in April and May of 1988?

A. Yes, I do. But my opinion would be not primarily because of the Alzheimer's. If I follow your course of questioning here, you are wondering whether his Alzheimer's kept him from feeling pain at that point. And whereas that's possible and certainly may be part of anything that he received in terms of pain sensation in his brain, I feel that most of the patients that I've had that have decubitus ulcers, the ulcers themselves are painless.

Q. That wasn't my question.

A. Okay,

Q. My question is whether you have an opinion as to whether Wilbur Hofelich was able to feel pain in April and May of 1988?

A. Okay. I found nothing from the record that indicated to me that he was in pain.

Q. That wasn't my question.

MR. FULTON: That's his answer, though.

BY MR. DELBAUM:

Q. Well, what I want to know is not whether you observed anything that indicated he was in pain --

A. All right,

Be -- but whether you have an opinion as to whether he was capable of feeling pain in April and Play of 1988?

A. Okay. I think he was probably capable of feeling pain,

Q. In April and May of 1988?

A. Yes,

Q. Okay.

A. For instance, if you were to pinch the man, I think he would have felt a pinch, from what I can tell from the record,

Q. Do you have an opinion as to the cause of the necrosis of his coccyx which was found when Dr. Trillis performed surgery on him?

A, Cause of the necrosis?

Q. Yes. Do you have an opinion as to the cause of the necrosis of his coccyx?

A, The same as the cause of the ulcer,. I would -- eight things that I listed as the cause of the ulcer would help contribute to the necrosis of the coccyx.

Q. Do you have an opinion as to whether the necrosis of the coccyx was independent of the decubitus ulcer formation or was related in some way to the existence of the ulcer?

A, My opinion is it was part of the ulcer.

Q. Do you feel that an examination of Wilbur Hofelich by you would be of any help to you in formulating the opinions you have in this case?

A. I can't see why, There is a time period that has passed since then and I don't think that would have much bearing over our trying to figure out what happened in the spring of '88.

Q. What if anything do you know about the nursing home ombudsman program?

A. I know that it exists, that's about it,

Q. Do you know what its function is?

A. Its function is as a patient advocate.

Q. Do you know where it gets any authority to act as a patient advocate?

A. I believe that it's a federally funded program, That's a belief, I don't know the law.

Q. Do you know any physicians who are on the Board of Trustees of any nursing home ombudsman program?

A. No, I don't.

Q. When you take on a new patient in a nursing home, how soon after the patient enters the nursing home do you assess their medical condition?

a. Anywhere from the time they come in to the maximum allowable, which I think is like 28 days. If a patient comes into a nursing home and they have a complete chart with a recent medical assessment by another physician and they're stable, it's possible that I could wait for a month before I saw them. Unlikely,

but possible,

Q. What is your opinion, if you have one, regarding how frequently -- strike that.

Does a physician who is caring for a patient in a nursing home and who is caring for a deteriorating decubitus ulcer for the patient in the nursing home, one that has some necrosis and purulence, have any obligation to assess the nutritional status of the patient?

A. Yes, I think the physician should pay attention to their nutritional status of the patient.

Q. What should the physician do to pay attention to the nutritional status?

A. Should make certain that the patient is eating and taking fluids properly,

Q. How can the physician make certain that the patient is eating and taking fluids properly?

A. From what records and advice are given to him by the staff at the nursing home. And the physician could order laboratory studies, as has been done on Mr. Hofelich.

Q. When was it done on Mr. Hofelich?

A. Throughout the course of his stays there were occasional serum proteins and albumins done,

Q. His stay at Manor Care?

MR. SEIBEL: Well, I don't mean to interrupt the Doctor, but I will for a second.

THE WITNESS: Okay, I don't know when I -- they were in the records that I saw.

MR. SEIBEL: I have my own compilation of the serum albumin and total proteins that were taken from October of '87 through February of 1989, and if you would like to short circuit the Doctor's review of those, I am not going to give this to you because I prepared it, but they're taken directly from the records, if you want him to go through the records,

MR. DELBAUM: What you are saying is is it all right if he looks at your notes? Yes, it's all right if he looks at your notes.

MR. SEIBEL: Yes.

THE WITNESS: There. There we go. All right.

BY MR, DELBAUM:

Q. Were the studies done that you were just referring to while Wilbur Hofelich was a patient at Manor Care in North Olmstead?

A. There was one done.

Q. When was that?

A. On April 26th, 1988.

62. And what did that show?

A. Showed an albumin of 3.1 and a protein of 5.4.

Q. What is the significance of the albumin of 3.1?

A. Well, the significance, as I said, because we don't know what his kidney, his renal status was, the significance is debatable. The fact is that they were both low,

Q. Which is an indication of malnutrition?

A. Or protein losing nephropathy.

Q. In any event, whether it's because of the protein nephropathy or because the patient isn't eating enough, the patient's body is not getting enough protein; isn't that correct?

A. No, no, the patient's body doesn't have enough protein in the serum, that's correct; but why that protein is low is what is at question.

Q. Okay. What obligations, if any, should the physician have to investigate the cause of the albumin and protein being low under the circumstances when they were taken on April 26th, 1988?

A, I'm not sure that the physician has any obligation to investigate that given this man's general health picture, his quality of life, and the total bearing it may or may not have on his decubitus. I'm not

convinced that any investigation is necessary,

Q. Is it your opinion that the bearing of these readings on his decubitus was probably insignificant?

A. I think that the serum protein was only one of the many problems that contributed to his decubitus ulcer, and if you list out all of those contributing factors, any one of them would have to be considered insignificant simply because of the large number of problems that he had,

Q. Do you 'nave any information regarding the status of Wilbur Hofelich's hydration in April and May of 1988?

A, I -- no, I would have to consult the records.

Q. I would like you to do that.

A. I bey your pardon?

Q. I would like you to do that,

A. Specifically look for what?

Q. What information there is regarding his hydration in April and May of 1988.

A. Urn-m --

Q. Let me back up for a second,

A. All right.

Q. Is the extent of his hydration of any significance?

A. With the ulcer?

Q. Yes.

A. I really, I can't think of a way that being dehydrated specifically affects the ulcer, Indirectly being dehydrated can make one have an altered mental capacity, but direct influence of hydration and an ulcer, I can't, I can't draw any direct conclusion there, or direct connection.

The other end of it is, of course, that he was hydrated enough that he was urinating and keeping the ulcer wet, and that, that was an unfortunate circumstance,

Q. Would you agree that malnutrition interferes with the ability of the decubitus ulcer to heal?

A. I would,

Q. Can you tell me what your fees are for providing expert assistance in this matter starting with report through testimony?

A. I have riot sent a bill yet for my report, but I normally bill at the rate of 150 an hour for preparing a report.

Q. And how about for time in deposition?

A. $500 for the two hours.

Q. About $500 for two and a quarter hours?

A. Whatever.

Q. Okay.

MR. DELBAUM: I don't have any other questions. Thank you, Doctor.

THE WITNESS: Ready to quit?

MR. FULTON: I have three, I have three questions.

- - -

BY MR. FULTON:

Q. If you just look at your report.

A. All right,

Q. Does your report state, the third paragraph, page 1, "Neither his wife's action nor those of the nursing home staff or Dr. Suntala was responsible for the course of Mr. Hofelich's illness; he was a victim of his disease"?

A. That's what it says.

Q. Does it also say near the end of that paragraph, "Reasonable caring people tried to prevent the ulcer formation, and once it developed the attending physician directed numerous acceptable and appropriate methods of treatment to try to help it heal," does it say that?

A. It says that.

Q. And on page two, in the second paragraph does it say this, quote, "Resident care plan nursing

service" sheet says the patient was to be repositioned every two hours with two assistants daily. That "data sheets" in the chart are initialed indicating the staff turned him "q 2 H while in bed," "keep off back" was noted on the flow sheet, also."

"These flow sheets were evidently a new addition to the chart and the same information was recorded in "interdisciplinary progress notes" for his first Manor Care admission."

"His nursing care at Manor Care is documented as a reasonable standard of prevention and then correction of his ulcers." Does it say that?

A. It says that.

MR. FULTON: That's all I have,

MR. SEIBEL: We will waive signature.

MR. DELBAUM: I don't want to waive signature.

MR. SEIBEL: It's the witness's -- the witness waives.

- - -

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

- - -

C E R T I F I C A T E

STATE OF OHIO,)
) SS:
SUMMIT COUNTY,)

I, Laura E, Pavlick, an RPR and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, J. JOSEPH PAYTON, D.O., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to Stenotypy in the presence of said witness, afterwards transcribed upon a computer; and that the foregoing is a true and correct transcription of the testimony so given by the witness as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Akron, Ohio on this 7th day of March, 1990.

Laura E. Pavlick

Laura E. Pavlick, RPR and Notary Public in and for the State of Ohio.

My Commission expires December 4, 1990.