The State of Ohio,)
) SS:
County of Guyahoga.)

Doc. 381

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IN THE COURT OF COMMON PLEAS

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WILBUR HOFELICH, ET AL.,

Plaintiffs,

vs.

MANOR CARE OF NORTH OLMSTED, INC., ET **AL.**,

Defendants.

Case No. 167165
Judge Ralph A. McAllister

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DEPOSITION OF JEFFREY ADAM ROSS, M.D.
Wednesday, March 14, 1990

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Deposition of JEFFREY ADAM ROSS, M.D., called by the Plaintiffs herein for examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Mary Ann Koval, a Notary Public in and for the State of Ohio, at the offices of Gallagher, Sharp, Fulton & Norman, 7th Floor, Bulkley Building, Cleveland, Ohio 44115, commencing at 10:00 a.m., the day and date above set forth.

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APPEARANCES:

On Behalf of the Plaintiffs:

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On Behalf of Defendant Manor Care of North Olmsted:

Burt Fulton, Esquire
Timothy Fitzgerald, Esquire
Thomas Covey, Paralegal
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On Behalf of Defendant Christopher Suntala, M.D.:

Robert C. Seibel, Esquire
Jacobson, Maynard, Tuschman & Kalur Co, L.P.A.
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JEFFREY ADAM ROSS, M.D.

called by the Plaintiffs for examination under the Ohio Rules of Civil Procedure, after being first duly sworn, as hereinafter certified, was examined and testified as follows:

EXAMINATION

BY MR. DELBAUM:

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

A Jeffrey Adam Ross.

Q You are a physician, is that correct?

A That's correct.

Q Dr. Ross, my name is Charles Delbaum. We were introduced earlier. I represent the plaintiffs in this action, Wilbur and Grace Hofelich. The purpose of this deposition is for me to learn more about your opinions that you will be giving in this case that you've given in your report and more about the bases for those opinions.

During the deposition, if I ask you any questions that you don't understand, please tell me that and I will be glad to rephrase the question, is that all right?

A Fine.

Q And if you answer a question, then I am going to assume that you understood the question, okay?

A Okay.

Q Have you been deposed before?

A No, this is my first deposition.

Q Okay. Probably Mr. Fulton mentioned to you, and if he didn't, I will, that all your answers should be verbal. Yes or no if it's a yes or no question, an explanation if you need to do that, but shaking your head is fine for you and me, but the court reporter can't really get it down, okay?

MR. DELBAUM: I did tell him how precise you were, that you crossed every T and dotted every I. That's what I did tell him.

Q I'm not sure that you answered my last question verbally.

A Yes, I understood.

Q Good. In your report you listed certain records and depositions that you had reviewed. Have you reviewed any since then?

A No.

Q Is there any additional information that you've received about the care and treatment of Wilbur Hofelich or about his medical condition in 1988 or 1989 since you wrote the report?

A No, I have not.

MR. E'ULTON: There were some depositions sent to him, thouyh. Those two depositions that I sent to you, whether that came before or after.

THE WITNESS: That came before.

A This is what I reviewed,
Q It's all listed in your report?
A Yes, except I didn't list complaints. But all the depositions, records that I had, are in this stack.
Q Okay. Was any information provided to you in correspondence?
A No.
Q Have you evaluated the care and treatment that Dr. Suntala rendered to Wilbur Hofelich while he was his patient at Manor Care?
A The focus of my review of the records was directly related to nursing home performance, and, obviously, I had to look at what Dr. Suntala did with reference to that. But 1 didn't focus specifically on all of his activities, just as it related to the nursing home care.
Q Okay. Do you have an opinion as to whether Dr. Suntala's care was consistent with the standard of care for physicians caring for patients in nursing homes?
A I do have an opinion.
Q What is that opinion?
A I think it was appropriate to the situation.
Q Okay. Do you know how Mr. Fitzgerald came to contact you regarding this case?
A Not specifically.
Q Did he indicate to you where he had gotten your name?

A Oh, in that sense, I've done some other work for Gallagher, Sharp in the past.
Q What type of work have you done for them?
A It's, I would say, my seventh case I've been involved with reviewing records within the last year.
Q What kinds of cases have you reviewed for this firm?
A Some personal injury cases and several medical malpractice cases.
Q Have those all been on behalf of the defendant?
A Yes.
Q Have you ever reviewed a medical malpractice case for the plaintiff?
A No, I have not,
Q Have you ever been asked by a plaintiff's attorney to review a medical negligence case for a plaintiff?
A No, I have not.
Q Apart from the medical negligence cases you've reviewed for Gallagher, Sharp, have you reviewed medical negligence cases for other law firms?
A No, I have not.
Q Would you tell me, please, what the purpose of charting information in medical records is?
A This is probably multi-fold. One is to document what has been done. Two is to have an effective vehicle for communicating from one shift to another shift; one type of

allied professional person to another type of allied professional person or from physician to nurse, that type of interaction, and then a medical legal record of what has transpired.

Q Those purposes all apply to any medical institution, whether it's a hospital, a nursing home or any kind of medical institution, isn't that correct?

A That's correct.

Q Medical personnel are generally educated in the need to do appropriate charting for patients that they are caring for, is that also correct?

A Correct.

Q Is it also generally accepted that if something isn't charted, it wasn't done?

MR. FULTON: Objection. Go ahead and answer what you think. I have an objection to it, but go ahead and answer.

A Just repeat the question, please.

Q Is it generally accepted that if something wasn't charted, it wasn't done?

A Not necessarily.

Q Under what circumstances would that not be true?

A Oftentimes in critical situations there is not complete documentation of anything that transpires. Sometimes, I will say, nursing activities that are -- I hate to use the word

routine, but sometimes things that come under the daily care of patients may not necessarily be charted.

If someone wipes your nose as a patient, they won't necessarily chart that. If they wipe your nose and then you have a nose bleed and become hypotensive, they will chart that.

Q If I can clarify a little bit further on both of those examples. One type of example I think you were discussing is critical situations.

A Right.

Q You're referring to emergency situations where time is critical and, therefore, one wouldn't expect that someone would be able to make notes at or about the time of the event?

A Correct, or there may be such a length of what transpired that you may summarize or just give an overview of what transpired without documenting every specific action that took place minute by minute.

Q Okay. And the other type of situation is one where there is daily care that is of no significance to the patient's care plan, is that a fair statement?

MR. FULTON: Objection.

A I don't think that's what I said. I think the point I'm trying to make is that there are situations where something becomes routine caring of the patient. Now, that's

different from a nursing standpoint than a physician standpoint but mainly because the physician tends to be terribly focused in a brief period of time in the interaction where nursing care goes on 24 hours a day.

So there are many activities that go on by nurses that are not charted. It doesn't mean because it wasn't important or there wasn't time to chart it. It may be part of their care plan that didn't require charting.

Q Insofar as a nurse is carrying out a doctor's order to do a certain treatment, that should certainly be charted, should it not?

A Yes.

Q If that's not charted, isn't it a fair assumption that it wasn't done?

MR. FULTON: Objection. Go ahead and answer.

A Depends on what the order was.

Q In what way does it depend on what the order was?

A I think medication orders, therapy orders, should be charted and carried out via an order and a charting mechanism. I think when you get back to daily care of patients, it oftentimes doesn't get charted and doesn't mean it's not been done. Did you follow that?

Q Yes, I did, and I understand what you're saying.

A Okay.

Q With respect to therapy orders which are not charted, is it then a fair assumption that they were not done?

MR. FULTON: Objection.

A If the therapy that I was speaking to was not charted, I would say it probably was not done.

Q Do you have an opinion as to whether Wilbur Hofelich was able to feel pain in April and May of '88?

MR. SEIBEL: Object.

A It would only be an assumption. I have no definite proof from what I've read whether he could feel pain or not feel pain.

Q I would ask you if you have something that's in between an assumption and definite proof, most of us refer to that as an opinion. You may not have an opinion. I'm not trying to have you form one if you don't have it. If you do have an opinion to a reasonable degree of medical probability, then I would like to know what it is. If you don't have an opinion to a reasonable degree of medical probability as to whether he could feel pain or not, that's fine.

A Given what I have reviewed, I would say I don't have a medical opinion.

Q Is it below the standard of care for nursing homes in this community to rely heavily on agency nurses and nurses' aides?

A No.

Q Reliance on agency nurses' aides and nurses does present potential problems for patients in nursing homes, does it not?

A It can.

Q What are some of the reasons for those problems?

A It's loss of continuity of care and we see this happening at all of the institutions, be they acute care facilities or extended care facilities, and it relates to nursing shortage. So agency nurses are a reality of the current state of the medical community.

Q Is the staff of a nursing home normally expected to be able to position a 150 pound rigid person as needed?

A There should able staffing to make an attempt to move patients to necessary positions to be cleaned, to be toileted, et cetera.

Q Or to keep them off their back if the order of the physician is to keep them off their back?

A To make attempts to do that. There should be able staffing to do that.

Q Okay. Should the physician caring for an elderly patient with a decubitus ulcer in a nursing home assess whether dead tissue is present before ordering Duoderm to treat the ulcer?

MR. SEIBEL: We just testified that he thinks Dr. Suntala's care was appropriate.

You're asking him the standard of care question as to Dr. Suntala and I will object.

MR. FULTON: I have another statement I want to make with respect to that statement. I don't think that he has gone into this case with respect to the care and treatment of Dr. Suntala, although he said it was appropriate. I'm not going to say he can't answer the question, but if he didn't go into this and doesn't have an opinion with respect to that, I would instruct him not to answer. But go ahead and answer the question.

MR. DELBAUM: Let me further our discussion for just a moment and see whether it gets us anyplace useful. If both of you, Mr. Seibel and Mr. Fulton, will stipulate that the doctor will not offer any opinions about the care of Dr. Suntala at the trial, then I won't ask him any questions about the care that Dr. Suntala rendered.

MR. SEIBEL: I can't stipulate on behalf of this witness or what Mr. Fulton is going to ask.

MR. FLJLTON: I'm not going to ask him with respect to Dr. Suntala. I'm going to

ask him with respect to nursing home personnel. However, he did say he had to look at Dr. Suntala's care with respect to his interaction with the nursing home personnel. But I don't intend to ask him opinions about Dr. Suntala. I can't speak for what Mr. Seibel is going to do.

MR. SEIBEL: 1 haven't prepared my cross-examination of this witness yet for trial.

MR. DELBAUM: Then you can't stipulate that you won't ask him whether Dr. Suntala's care met the standard.

MR. SEIBEL: I can't instruct this witness not to answer anything, but 1 tell you I'm not sure whether I'm going to elicit that opinion or not.

MR. DELBAUM: I need to inquire then.

MR. **FULTON**: It's up to the doctor. My advice that I have given you is to the extent you've reviewed these records with respect to specific opinions regarding the treatment of decubitus ulcers, and I thought that question was asked specifically with

respect to Dr. Suntala as opposed to just the general treatment of the decubitus ulcer, as I recall the question. I may be wrong.

MR. DELBAUM: Well, I think you're wrong, although it's a quibble to some extent.

Q The question was, should the physician caring for an elderly patient with a decubitus ulcer assess whether dead tissue is present before ordering Duoderm to treat the decubitus ulcer?

A In general terms the answer is not necessarily. He doesn't have to see it. He could hear a description of the wound and make an attempt to apply Duoderm in an order form.

Q Understanding that he could rely upon a description of the wound from a nursing personnel, would that description be expected to include information about whether or not dead tissue is present?

A Usually when nurses notify physicians that there is some type of problem with the skin, they give a description, given the fact that nursing home physicians are not there on a daily basis by the nature of nursing homes. The result of that is that many skin care decisions are based on the people who are watching the skin on a daily basis and as described over the phone to physicians. And I would suspect that in the medical community, the standard of care is such that there would be physicians who would apply Duoderm by order

form by a description from a nurse.

Q Okay. I'm not making my question clear enough then. Let's assume that the nurse tells the physician that she has observed the decubitus ulcer and that there appears to be dead tissue present in the decubitus ulcer.

A Yes.

Q Would it be appropriate for the physician to order Duoderm under those circumstances?

MR. SEIBEL: Objection.

A It may be appropriate because Duoderm acts as a debridement and protective vehicle for a wound. I would have to hear the description of a specific wound and then make my judgment as a physician what I think would be appropriate to that description.

Q What is the mechanism by which Duoderm acts as a debridement?

A Well, my understanding is that, one, it creates a moist environment under a barrier such that there is epithelial growth and fibroblast stimulation and that ultimately you would create some debridement and regrowth of healthy granulation tissue. Now, it depends, once again, on what the nature of the wound that was described to me would be.

Q Are you aware that at times when Wilbur Hofelich was up in a gerichair in April 1988 a rubber ring was placed under him?

A Yes, I am.
Q What are the problems that can be associated with using a rubber ring for a patient like Wilbur Hofelich, if any?
A The goals of using a rubber ring is to readjust pressure upon skin surfaces. Obviously, the problem with any patient is, are they effectively positioned on the rubber ring and where their skin breakdown is relative to the ring at the time of positioning. And so without seeing it in actuality, it's hard to really say whether good or bad became of it for this patient.
Q It would depend on how large the rubber ring was that he was sitting on?
A Right, how effectively he could be maintained in a chair, what was his position in the chair, et cetera.
Q Is it a nursing decision or a physician's decision whether to use a rubber ring for a patient?
MR. FULTOM: I have an objection. It might be both.
A Well, I think the answer is it could be both. You know, there is some liberty taken with the daily care of patients in nursing homes and hospitals for their comfort when they are in various positions. Every time someone has a rubber ring or a pillow or a blanket, that isn't orchestrated by the physician. It may be orchestrated by nursing decisions.

Q Are you aware that Manor Care had a skilled care unit at the time Wilbur Hofelich was a patient there?

A Yes, I am.

Q Do you have an opinion as to whether Mr. Hofelich would have qualified as a skilled patient in April or May of 1988?

A I think that's on the basis of Medicare requirements and I think merely having a decubitus ulcer doesn't qualify you for skilled care. But I would have to check that with Medicare and Medicaid regulations at the time.

Q Do you know what treatment of a decubitus ulcer would qualify a patient for Medicare? Are you aware of any level of treatment, not necessarily the least level, but some level of treatment of a decubitus ulcer which would qualify?

A At this point, I would have to say I don't know the regulations specifically.

Q Do you know what services, if any, would have been available to Wilbur Hofelich an the skilled unit that weren't available to him in the Alzheimer unit where he was residing?

A That, I do not know.

Q Would you tell me what your understanding of the usual progression of Alzheimer's Disease is?

A Okay. Alzheimer's Disease is a central nervous system disease where pathologically there is destruction of brain tissue. People can have a presenile dementia, but the dementia can take a very significant form beyond just

normally being confused in presenile dementia to the point of not being able to function effectively in terms of the daily activities of life to cognitive dysfunction and physical dysfunction, and I think that's what really separates it to a greater degree from just growing old and being a little bit demented.

Q Will you describe the progression of the disease for us, please?

A I think that we see patients who have early or mild degrees of confusion, and as the confusion progresses, they become more confused, disoriented with the loss of the ability to perform certain activities of their daily life that were basically second nature to them to really becoming dehumanized in a sense. They go from being very functional people to becoming over time just total care patients near the end of their life.

The rate of progression is variable and I think what may happen is that we just are not sharp enough to sense early on how significant people's diseases may actually be, If we don't do formal mental status testing, they may be teetering along with family assistance. Oftentimes, by the time people reach nursing home levels, it's really sort of exploded into a rather significant level where people are really dysfunctional.

Q If the patient with Alzheimer's lives long enough, the

end stage can be a vegetative state, is that correct?

A Correct.

Q And in the vegetative state, the patient basically just lies there and is unable to have any interaction with the outside world, is that basically correct?

A It can happen that way.

Q At that stage, it wouldn't be unusual for a patient to be non-responsive to pain, is that correct?

A It could be such.

Q Have you, in your experience, ever seen a patient who had Alzheimer's disease prior to the vegetative state who was non-responsive to pain?

A Yes, but I just would like to say that one of the biggest problems with this group of patients is that at one moment in time they may tell you they have pain. Then they forget that they have pain, so to speak. They can identify a problem and then, just because of their cognitive function, not be able to express or really focus on that and it becomes sometimes insignificant to them.

And I've witnessed that in my nursing home experience. At 8:00 o'clock in the morning, someone's complaining about their knee hurts. You go back at 8:15 and talk to them about their knee and examine their knee and there is nothing you can elicit from them and they are pleasantly confused and oblivious to what was going on 15 minutes before. It's hard

to interpret what they really related. Was it they really forgot they had pain? Was it they really didn't have pain ever at all?

Q Or the pain went away?

A Or the pain went away. So you're dealing with a patient who is hard to really piece together as to whether they experience pain or not. And that's why in the previous comment I said it's hard to assume whether this gentleman could feel pain or not from the records.

Q Well, let me ask it this way: Have you ever observed Alzheimer's patients prior to the vegetative state who did not respond to a painful stimulus by trying to avoid it or by indicating that it wasn't painful?

A There are Alzheimer's patients who respond to pain, if that's what you're asking.

Q Well, I'm asking whether you've actually observed any who didn't respond to painful stimulus but who were not in a vegetative state.

A Yes.

Q Under what circumstances?

A Just during exams of clinical problems that have come up. You examine the patients and their pain threshold is either very high or they just didn't seem to flinch during the examination, and yet I would suspect that they should have some problem but did not.

Q How often have you seen that?
A I don't think I can -- half dozen times.
Q Have you cared for patients in nursing homes who have decubitus ulcers?
A Yes, I have.
Q And have you cared for such patients whose decubitus ulcer has been increasing in size?
A Yes, I have.
Q And how often do you visit such patients?
A Well, I have two aspects of my nursing home practice. One is private patients in nursing homes who I see once a month. Then for the last nine months I have been a staff physician at a nursing home where I round three mornings a week and one Sunday ever sixth in a facility that has a seven days a week physician in attendance for part of the day as well as a full-time medical director.

So there is a distinction in the patients that I see and how often I see them.

Q With respect to the private patients in nursing homes whom you see generally every 30 days, did you say --
A Correct.
Q -- have you on occasion seen patients who have decubitus ulcers that are increasing in size more frequently than every 30 days?
A No, I have not.

Q In your opinion, is there any relationship between the state of a patient's hydration and his ability to heal a decubitus ulcer?

A Patients do best when they are well-hydrated.

Q That includes their ability to heal a decubitus ulcer?

A I would say, yes.

Q Whose responsibility is it to assess the state of a patient's hydration? The physician? The nursing home? Both or neither?

A Both.

Q All right. Have you reviewed the laboratory tests concerning Wilbur Hofelich insofar as they give information about the state of his hydration in the spring of 1988?

A I've looked at them.

Q Did you gain any information which was pertinent to determining whether he was probably dehydrated in the spring of 1988?

A May I pull them?

Q Sure. At any time during the deposition you can refer to the records.

A Okay.

MR. FULTON: Just say what you're referring to, whether it's a Fairview record or the nursing home.

A Okay. I'm looking at a Smithkline Laboratories

computer printout of 4/26/88, which included a basic set of blood chemistries and a blood count, and also one on 4/29/88.

From looking at the blood chemistries, I would not say he was profoundly dehydrated by any means. We look at BUN and creatnine and the sodium, and on the basis of that, on both these occasions I would not say this man was profoundly dehydrated. Minor degrees of dehydration could be seen at this level of BUN and creatnine ratio, but I will stand by that in saying he was not profoundly dehydrated.

Along those lines, if you look at the hemoglobin and hematocrit and you view that as a guide to wonder if the patient is hemoconcentrated, his hemoglobin and hematocrit over those several days is in a fairly normal range, and, in fact, it fell from the 26th to the 29th as opposed to increasing as if he were hemoconcentrated. So that also says that he was not profoundly dehydrated.

It's always best to be able to see the patient and look at skin turgor and mucous membrane, et cetera, before you can really make assessments on labs because people are still more important than labs even in this high tech era.

Q Would you agree with me that patients with deteriorating decubiti should receive extra protein in their diet?

A Yes.

Q What method would you use to calculate how much extra

protein?

A Usually with the assistance of a dietitian and an assessment of what the current caloric intake is, what you suspect may be the protein catabolic loss and come up with what you think is a reasonable amount of total daily calories. And usually I say we would use the assistance of a dietitian to do that.

Q How would you attempt to assess the protein catabolic loss?

A In this setting, a nursing home setting, I think most people would make a gestalt. I don't think the standard of care would be such that people would do rigorous urinary nitrogen loss and aggressive maneuvers, and I think the approach of choosing a caloric intake that you think would be appropriate and then trying to fulfill that with supplements and oral intake from a standard diet would be the way most people would approach it.

Q You're saying that most people wouldn't order blood tests or urinary work?

A In this patient's setting, I would say no.

Q Why is that?

A I think it gets back to looking at the level of acuity with which people handle nursing home patients. Many people try to provide them with dignity, food, shelter, cleanliness, tender loving care, and as people are debilitated or

approaching the end of their lives, you try not to come up with aggressive approaches and costly approaches to working up problems. That doesn't mean they are neglected. It just means they take a different point of departure. I'm speaking from myself and many of the colleagues that I work with.

A 30 year old who has major surgery in a hospital, they may go ahead and do intravenous hyperalimentation and workups of metabolic caloric use. I think that the standard of care is such that in most nursing home settings, people wouldn't be aggressive in trying to establish caloric needs but would still want to provide them.

Q Would a simple blood test have been of some value in assessing the patient's nutritional status in early April of '88?

A I think when you look at the lab work done in the end of April, we see the albumin was slightly low and total protein, that's a gauge of nutritional status that we would get. Whether it was done in the early part of April, it wasn't crucial because supplements began in this patient in March when they noticed several pounds of declining weight and somewhat diminished oral intake.

If I'm not mistaken, I think I said that was March 19, '88 that supplements were begun. That's correct.

Q What would the cost have been of the blood tests which would have provided some gauge of nutritional status?

A The cost?
Q Yes. Few dollars?
A Possibly.
Q So that would not have been a costly or aggressive thing to order.
A Not a costly or aggressive thing to order.
Q Whose responsibility is it to assess the patient's nutritional status in a nursing home?
A It becomes part of the dietitian's responsibility of the nursing home and the physician.
Q But not the nursing staff?
A Nursing staff identifies and tries to carry out that the patient is fed, and if there are gaps in terms of feeding or inability to feed, it's their job to notify those people, meaning the dietitian and the physician, of ways to try and improve that situation.
Q In your report you mention that the Foley catheter was removed in January 1988 due, at least in part, to the family's wishes.
A Yes.
Q And it was reinserted April lst, 1988, do you recall that?
A From what I can see in the records, that would be the time I place reinsertion.
Q Do you have an opinion as to what effect, if any, the

removal of the catheter had on the progression of his decubitus ulcer during late February and during March 1988?

A Given the fact the patient was bowel incontinent and bladder incontinent, they may have contributed together. But even had the Foley been in alone, you still have a lot of fecal material in the way. So it's a contributing factor but I must say that Foley's have their side effects, too. And in a man who has had frequent urinary tract infections and someone who has had urosepsis in the past, it's not a decision to leave it in that's taken lightly.

Q So it was also not unreasonable for the family to ask that it be removed in January of 1988?

A Nor was it unreasonable on the part of the doctor to allow it to be removed.

Q And the decision as to whether it was better for the patient to reinsert it in light of its possible contributory role to the progression of a decubitus ulcer versus the possibility of repeat problems of urosepsis or other related Foley problems was one for the physician?

MR. SEIBEL: I'm going to object because your question assumes, I think erroneously, that for the entire time this decubitus ulcer worsened. I don't think the records bear that out. But with that objection, you can go ahead and answer the

question.

MR. FULTON: Read the question back.

(Record read.)

A Ultimately the physician has to give the order to allow Foley's to stay in.

Q Or to be reinserted?

A Or to be reinserted,. but in any facility, that has to be a physician's decision once it's in to stay in or be reinserted.

Q If I understood part of your testimony a moment ago and I am isolating it, admittedly, not trying to repeat everything you've said, but the fact that the Foley was not being used in late February and March 1988 would probably have contributed in some measure to the progression of the decubitus ulcer.

MR. SEIBEL: Object.

MR. FULTON: You're being asked to assume in that question. I want you to be careful. about your answer.

A Well, it becomes an assumption that it could contribute, but as I said, he also was incontinent of bowel, so dirty products in the patient's decubitus stream, whether urine or stool, is equally bad. You're asking me to try and separate a percentage, and I could not do that.

Q No, I wasn't going to ask you that. I was only going

to ask you whether it was probably a contributing factor without being able to measure how much the contribution was.

A It could have been a contributing factor.

Q Would you agree with me that if the nursing home staff did not keep Wilbur Hofelich off his back most of the time in March, April and May 1988, that that failure would be below the standard of care for a nursing home?

MR. FULTON: I have an objection, but go ahead and have that read back. This is an assumption now, which is permitted under the law.

MR. DELBAUM: It's a hypothetical question.

(Record read.)

A The way in which I have to answer that is that if they did not make attempts to keep him off his back, it would be below the standard of care of a nursing home. If they made attempts that were unsuccessful, that's a different point. And you can't fault them, as I wrote in my report, as if they did nothing when it may have been a difficult maneuver to maintain this man off of his back.

Q To clarify your answer, would you also agree that if they didn't attempt to keep him off of his back most of the time in February, March, April and May of 1988, that that failure would be below the standard of care?

A If they did not make attempts to do that, I would say that would be below the standard of care.

Q Okay. Would you also agree that a nursing home is normally expected to take steps to minimize the pressure on a decubitus ulcer which is getting worse?

A Yes.

Q What steps are normally expected with respect to a patient like Wilbur Hofelich, who is rigid and can't cooperate in his own care, in order to minimize the pressure on a decubitus ulcer on his coccyx?

A Frequent turning usually at the two hour level, and in that situation, you would have to maintain him on a side to side schedule. That's the only way pretty much, or on his stomach, which would be very difficult for the patient to tolerate. So you're talking frequent turning with some type of supports to try and maintain him on his side.

Q What type of supports would normally be expected to be used to attempt to keep him on his side?

A Pillows, rolled up blankets, rolled up towels, something to that effect. Occasionally they might try to restrain him in that position, but that becomes quite difficult for the patient to tolerate long term.,

Q The pillows, rolled up blankets, towels, et cetera, that you were referring to would be used behind the patient when he's on his side, is that correct?

A Right, and between his legs trying to create an effective position so that the patient doesn't begin to slide.

Q And how effective are pillows, rolled up blankets or rolled up towels in keeping a rigid patient on his side?

A You might do well and you might not do well.

Q Under what circumstances would you expect to do well?

A Probably if you tied him down to the bed. I'm not trying to be facitious. It's just that to try and maintain people side to side who are not very mobile is exceedingly difficult. But as you can imagine, if you tied someone down to the bed for the bulk of their day, that's almost torture and the trade-off is to try to bolster the patient the best you can and make an effort to turn him from side to side on a several hourly schedule.

Q Under what circumstances would you expect the pillows or rolled up blankets and so forth behind the patient to be ineffective in keeping him off his back?

A I think I've really been describing that. I can't give you a specific circumstance. It's body habitus. It's what kind of contractures the patient has, how rigid he truly was. I don't think I can give you a scenario in which it might fail beyond what I've described.

Q I don't know what the term "body habitus" means.

A That means your physique, your build. If you're 4',

10" and 100 pounds versus if you're 4', 10" and 300 pounds. One would be petite, small body habitus. The other would be a large body habitus.

I think Mr. Hofelich was 5", 11", so he was somewhat lanky. He was in the mid range of weight, 150 to 160-ish pounds. He had contractures. He was rigid. I think that affects his ability in a nursing home bed to be optimally positioned.

Q Just so I understand what you mean by the effect of body habitus, would you expect it would be harder to keep him off his back if he had weighed 250 pounds or easier -- and was 5', 11", same person.

Just so I make myself clear, same person, Wilbur Hofelich, everything the same about him except he weighs 250 pounds instead of roughly 150 some pounds. Would that make it easier or harder?

A I would assume it would be harder to keep him off his back as his weight increased due to rigidity contractures and his height. But don't underestimate the fact that he was 160 pounds and still those same additional features were present, which made it difficult.

Q Do you have an opinion as to whether Wilbur Hofelich suffered from a protein nephropathy in the spring of '88?

MR. SEIBEL: A protein losing nephropathy?.

MR. DELBAUM: Correct. That's what I'm referring to.

A From the records that I have seen, I would say no.

Q Because of the way lawyers ask questions and legal requirements, we condensed two things into one question or response there, I think, and I want to clarify that.

I asked whether you had an opinion as to whether he probably had a protein losing nephropathy, and I think your answer is, "Yes, I have an opinion, and the opinion is that he probably did not have a protein losing nephropathy."

MR. SEIBEL: Based upon the records he reviewed.

MR. DELBAUM: Correct.

A I will repeat it. Based upon the records I've reviewed, I have an opinion, and I feel that he did not have a protein losing nephropathy.

Q I just cut about ten minutes out of the deposition.

MR. FULTON: You can take all the time you want, but do you think you will be done by 12:00?

MR. DELBAUM: Oh, yes,

Off the record.

(Discussion had off the record.)

Q In the blood tests that we were looking at earlier, the second of the two for April 29, I have a question, if you

would pull that out, please.

A Yes.

Q The hematocrit level is somewhat low, is it not?

A No. On 4/29/88?

Q Yes. 39.3?

A No, that's fine.

Q For a man?

A That's fine.

Q What level is low for a man?

A For a 75 year old man, I would accept a hemoglobin of 13 and hematocrit of 39 as acceptable and I would say less than 35 or 36 would be low.

Q How about for a 40 year old man?

MR. SEIBEL: What bearing does that have on this case?

THE WITNESS: I will answer, if you don't mind.

MR. SEIBEL: I don't mind at all, Doctor. I think he's wasting your time, but go ahead.

A If you came into my office with a hemoglobin of 13 and a hematocrit of 39.3 and you were 40 years old, in and of itself I would not be concerned.

Q Okay. Apart from being concerned, though, that would be considered low for somebody in his 40's, is that correct?

A No.
Q Okay. That's what I'm trying to get at.
A No.
Q It's not age-dependent. You mentioned for a 75 year old person.
A You have to understand something. People take hemoglobin and hematocrit hemolytic numbers and say this is what it should be. There are people that have anemia for a lot of different reasons. Sometimes it's chronic disease; sometimes because they lose blood, and that's why they have their anemia. There are people who have normal hemoglobin and hematocrits given their clinical status and if you look at a lot of 70-some year old people, this is an acceptable hemoglobin and hematocrit.

Now, they can give you rigid ranges for, you know, people and say everybody has to have a hematocrit of 45. That doesn't make any sense to me. I don't view numbers that way. You're looking at the oxygen-carrying capacity of hemoglobin and hematocrit as a reflection of the volume of those red cells in circulation. And I think this is fine.
Q I'm trying to understand, and the reason I asked you about people in their 40's is whether your answer is that for people in their 70's a hematocrit of 39 doesn't necessarily indicate a problem or whether you're saying for men in general it doesn't indicate a problem?
A Taking in isolation that hemoglobin and hematocrit, I

personally would view as acceptable for a 40 year old man or 75 year old man. I'm sorry I didn't clarify that.

Q The white blood cell count is somewhat high in the April 29, 1988 studies based on what the laboratory felt was the usual range of normal. Do you agree that it was high?

A It was elevated.

Q Do you have an opinion as to the probable cause of its elevation?

A Excuse me one second.

An elevated white count is an indication of an infection. I'm not trying to be facitious. The point is that it could be related to his decubitus. It could be related to the urine. It could be related to a process in his lungs. Could be related to a skin process removed from the decubitus. So all you can say is that at that point in time there was an elevation of the white count without a left shift, which means immature forms of white cells being present, and you would have to do an assessment of the patient to look for a source of infection.

Q Is it also true that elevated white blood count and diminished hematocrit are consistent with malnutrition?

A Diminished red cell count could be a manifestation of malnutrition with regard to iron, vitamin B-12 and folate. If you look at the hemoglobin, hematocrit, RBC, MCV, there is no indication from the CBC, complete blood count, if you look

at that in isolation that there was a deficit of components necessary to produce adequate amounts of red blood cells. I would not say, in my experience, that elevated white counts are seen in malnutrition states from my experience.

Q Do you know Dr. Suntala?

A No, I do not.

Q Would you describe for me, please, the stages of decubitus ulcer development?

A Okay. At the nursing home that I work at, they call it good and alert stage, which people don't talk about, where you just sort of suspect something might be there. Stage one is usually erythema. That's where most people really begin without any disruption in the skin's integrity to any significant degree.

Stage two, there is breakdown to the level of the dermis.

Stage three is into the deep subcutaneous tissue, and stage four is where you're very deep and you can get down to fascia, muscle, bone.

Q What treatment is appropriate for a stage two decubitus?

A Well, appropriate, there are a lot of options, cleaning the wound. Some people use mild soap. Some people use just sterile saline. Some people might wash it with peroxide. Someone may use Duoderm. Some may use Granulex. Some may

use Maalox. You can use sugar and Betadine. There are a lot of different vehicles to create debridement and healing. You're trying to just stimulate good, healthy granulation tissue to develop.

Now, stage two, stage three, you're kind of in the same ball park. But clearly you want to clean the wound and provide some stimulus for getting to healthy tissue.

Stage one is probably more just cleaning and maintaining skin integrity.

Q Well, my next question, which I'm sure you anticipated, is what's the appropriate treatment at stage three? Do you have anything to add to what you've already said about the stage two treatment?

A I think it's a continuum, and because there is no rigid rule, you can't open up a book that says what to do for this or this. So it's hard to say.

There are multiple options. You look at the wound and you make a decision on the basis of what you see. One nursing home I worked at on staff has a policy. The doctors don't even make an opinion with regard to how a wound is cared for. The medical director has established a policy and this is what they do in every situation. But at most nursing homes, there are a lot of options because you have a lot of different physicians and physician's discretions, and I can't say one is more right or one is wrong.

Q There is a skin treatment chart or skin care chart in the Manor Care records. Right, right on top of yours.
A Yes.
Q And in that chart the nurse who filled it out has different stages at different times. Do you see that section?
A Yes.
Q Do you have an opinion as to whether those evaluations of the stages were correct at the time they were made?
A I have to take these at face value. I wasn't there to see them. And it seems appropriate. I think early in February that might be a little bit of an over call. Stage two might have really been sort of a one and a half. Clearly if they have got some deep wound report, then I think they are fair in saying that it's moved on.
Q To a stage two?
A To a stage two.
Q As of April 11?
A Yes, and I think that, you know, clearly when you start saying, "Is it a 3," it's a matter of how deep they think the wound is.
Q So you wouldn't disagree with the assessment that it was a stage three on April. 18?
MR. FULTON: Objection. He said he had to take it at face value. He didn't see

the patient. Go ahead and answer.

A I would stand by what I said. If this is how the treatment nurse interpreted what she saw, it could be consistent with a progression that seems appropriate.

Q My question perhaps wasn't clear enough. Let me phrase the question a different way to get at what I'm looking for.

Do you have any basis on which to disagree with the nurse's assessment of the stages from April 11, 1988 on out until May 16, 1988?

A I don't doubt what they wrote here on the basis of what I've reviewed.

Q Do you have an opinion as to how much time was appropriate for Wilbur Hofelich to be up in a gerichair during March of '88?

A You said March of 1988?

Q Yes.

A Excuse me one second.

MR. FULTON: Is that how long he had been up?

MR. DELBAUM: How much was appropriate.

A What I'm referring to is really some nursing documentation of time in bed and gerichair time. In the month of March, he spent some daytime periods up in a gerichair. I can't tell you how much of that time on that

shift was spent in the gerichair and I think limited amounts of time would have been appropriate for his psychologic well-being and the family's well-being because that seemed like a lot of his interaction time.

But on the basis of the records, I couldn't tell you how much time he truly spent up in the gerichair and it would be impossible to really say what was the optimal amount of time. Clearly optimal time off of a decubitus, it's possible when he was up in the chair they were able to keep his decubitus -- well, less pressure upon it. And once again, that gets back to nursing and how successful they were of keeping him comfortable in the chair.

Q Are you able to give me a range of times that you believe were appropriate for him to be up in a gerichair in March, or are you not able to do that?

A Not really.

Q How about in April, 1988?

A Once again, I couldn't give you any magic number.

Q Or a range of times?

A Or even a range. Clearly it was dependent upon how successful anyone could be at maintaining less pressure upon his decubitus, whether he was in bed or in a chair. I don't think just being up in a chair in and of itself meant that it was impossible to provide him with somewhat of a pressure-free environment.

Q I assume your answer is the same for May of '88?
A Yes.
Q Did you want to look at something?
A I just wanted to refresh my mind, and the answer would remain the same as before.
Q What's your understanding of any problems with decubitus ulcers that Wilbur Hofelich had while he was at St. Augustine Manor?
MR. FULTON: He's still there.
MR. DELBAUM: Yes, I was going to rephrase that.
Q What's your understanding of any problems that Wilbur Hofelich has had with decubitus ulcers since he's been a patient at St. Augustine Manor starting in June of '88?
A My understanding would be that the coccygeal decubitus ulcer, which was debrided by Dr. Trillis, had slow improvement, at least at the time of the deposition of Dr. Santiago, although was not completely resolved. There was some new breakdown noted, as I recall, scrotal and sacral, and the doctor did indicate, that is, Dr. Santiago, that he still has problems with his skin integrity at the new nursing home.
Q Apart from the areas of the body that you've just mentioned, specifically, coccygeal, scrotal and sacral, are you aware of any problems with skin breakdown that Wilbur

Hofelich has had at St. Augustine Manor?

A Not beyond what I've just stated. I never saw records from St. Augustine.

MR. FULTON: I just asked Bob --

MR. SEIBEL: I have them.

MR. FULTON: He has them but --

MR. DELBAUM: I have them.

A You have them?

Q Yes.

A The only thing I'm referring to is the deposition of Dr. Santiago.

Q Right.

MR. FULTON: I don't know. I'm assuming you don't have them. I don't remember. 1 don't know why that would be, but if you want to show him something, fine.

Q Well, maybe we can simplify this. Any information you would have regarding decubitus ulcers of Wilbur Hofelich at St. Augustine Manor would come from the deposition of Dr. Santiago, is that correct?

A Correct, and he did make mention that that is still a problem for Mr. Hofelich.

MR. FULTON: I wouldn't want to be limited and not be able to use them at the time of trial.

MR. DELBAUM: I understand that. I'm trying to find out what his information is now.

MR. FULTON: Yes.

MR. SEIBEL: I think we have stipulated for the record as to their authenticity.

MR. FULTON: We did, yes,

MR. DELBAUM: Yes.

MR. FULTON: They were probably sent to me and I put them in the wrong file. I've done that before.

Q Showing you what has been marked for identification as Plaintiff's Exhibit 1, that is a copy of your curriculum vitae, is that correct?

A Yes.

Q Is that current or are there any additions to it that should be made to make it current?

A Probably two additions. For the last nine months, I've been a staff unit physician on an Alzheimer's unit at Menorah Park Nursing Home, although that will stop as of this week. And just that I'm on an advisory board for Upjohn Home Health Services. I'm in my second year of that position, which is a voluntary position.

Q Does your work with Upjohn have anything to do with the

care of decubitus ulcers?

A Not per se. It's really an advisory board to home health care services so that there may be decubitus ulcers being treated in the home setting by nurses going out to the home, but it's more of an advisory board just in terms of quality assurance and management and that kind of thing.

Q Approximately how many patients at Menorah Park are you caring for currently?

A I'm responsible for -- I think it's about 55 people.

Q Since you started at Menorah Park about nine months ago, approximately how many Alzheimer's patients have you cared for in total?

A I will say it's about 40-ish.

Q 40 who are no longer there?

A No. There has been some deaths and new patients and its focus is pretty much an Alzheimer's unit. There are some people who are total care who are more mentally capable. I'm trying to decipher in my mind how many people are Alzheimer's.

I would say 40. It's the net if I add them up and multiply or whatever.

Q Just so we're clear in communicating together, let me try it from this direction. Approximately how many patients have you cared for in total at Menorah Park, regardless of what their problem was, since you started there?

A I would say about 70.

Q 55 are still there and there are about 15 others where there has been some turnover?

A Right, and the turnover was related to death.

Q And of the roughly 70 total patients that you've cared for at Menorah Park, approximately 40 have been Alzheimer's patients?

A Correct, with varying levels in the course of their diseases.

Q How did you come to get the staff position at Menorah Park?

MR. FULTON: Wait a minute. That may be something he's not required to answer.

MR. DELBAUM: If you want to --

MR. FULTON: Do you want to confer? Do you have any trouble answering that?

THE WITNESS: No.

A I was interested in doing some geriatrics work. A job came long and I opted to take that job.

Q Apart from your work at Menorah Park, where else have you cared for patients in nursing homes?

A Suburban Pavilion, Judson Park and Margaret Wagner.

Q Can you estimate approximately how many patients you've cared for at Suburban?

A There was one patient there and there has been one

currently at Judson Park. There have been two at Margaret Wagner. All this spans roughly the last two years.

Q So is it a fair statement that over the last roughly two years you've cared for approximately four patients at nursing homes other than Menorah Park?

A That's correct.

Q How many of those were Alzheimer's?

A I would say none of the four that were there.

MR. FULTON: Did you say "one" or "none"?

THE WITNESS: None of those four. One patient had a dementia that I suspected was a non-Alzheimer's dementia.

Q When you were in medical school, did you take any courses that were related to the care of decubitus ulcers?

A No.

Q When you did your residency in internal medicine at University Hospitals of Cleveland, at VA and Case Western Reserve, from 1983 to 1986, did you have occasion *to* care for elderly patients with decubitus ulcers?

A Definitely.

Q Can you estimate approximately how many?

A No, I can't.

Q These patients were not in a nursing home setting, were they?

A They were all in an acute care hospital setting.
Q In your residency in diagnostic radiology between '86 and 1988, did you have occasion to care for patients with decubitus ulcers?
A No.
Q After you finished your residency in diagnostic radiology, you began private practice July of 1988?
A That's correct.
Q What's the nature of your practice been since July of '88?
A It's internal medicine representing patients in ages from 15 to 16 on up to 100 years of age. It's a suburban-based practice in Shaker Heights. I'm predominantly affiliated with St. Luke's but 1 also have privileges at Mt. Sinai and University Hospitals and a large volume of the practice that I have is an ambulatory Medicare practice.
Q Most of those patients are elderly?
A Yes. That's the nature of internal medicine in a lot of ways.
Q Have you practiced radiology at any time since July 1988?
A No. I did not complete that residency. I made a return to primary care that was by choice, so essentially the two years I spent doesn't place me board eligible. It was just two years of post-residency training. During the time I

was in radiology, though, I was practicing some internal medicine.

Q While you were practicing internal medicine and working on your residency in radiology, were you caring for any patients in nursing homes?

A Most of that was emergency room-based work or a clinic setting.

Q What areas do you teach as a clinical instructor at Case?

A Part of that title is because I teach residents at St. Luke's Hospital. In the last 20 months, I've attended on the medical wards five months. That's where I'm the physician of record for the residents on the staff service. And I teach weekly one day a week on the average in the medical resident clinic at St. Luke's. I taught one month as a preceptor in a clinical decision-making course at the medical school last April and I will be doing that again this May. That's at the medical school.

Q Have you had occasion to teach students about the care of decubitus ulcers?

A No.

Q Why will you no longer be affiliated with Menorah Park in the next week or so?

A It's a personal decision.

Q Have you entered into any arrangements with other

nursing homes to *go* on to the staff of a different nursing home?

A No, I have not at this point.

Q Have you taken any continuing education courses regarding or that included the subject of the care of decubitus ulcers?

A Not specifically directed to decubitus ulcer care.

Q Of the patients you've cared for in nursing homes, can you estimate how many have developed decubitus ulcers while under your care?

A I will say a third.

Q Can you estimate what percentage of that one-third have developed decubitus ulcers which have progressed beyond an inch in diameter?

A I'm just trying to remember.

Q I understand that's not something you think about every day.

A No, because I think about people. I don't think about ulcers.

I will say about five and one and) additionally, I would say one in the hospital setting. That was a patient who did not go on to a nursing home.

Q Can you estimate how many of the patients you've cared for at nursing homes have developed decubitus ulcers greater than two inches in diameter?

A It would be the same number. The group that I'm thinking about specifically, these people had, as I remember them, large decubitus ulcers, meaning, I would say, somewhere in the two to four inch range or one to four inch, if that's where you're taking me.

Q I understand. That point you just said, that there have been about five people roughly in your nursing home population who have developed decubitus ulcers that have been as large as one to four inches --

A Correct.

Q -- were all of those greater than two inches?

A I'm going to say yes.

Q Did you do any surgical debridement for any of the patients who developed decubitus ulcers greater than two inches?

A Surgeons were involved in -- I'm going to say two of them. I did not debride them myself manually, and the others had medical debridement.

Q In answering my question, which was unintentionally imprecise, how have you been thinking in your own mind of the dimension as being greater than two inches? What are you measuring? The size of the irritated tissue? The reddened tissue? The size of the hole that was there?

A I'm thinking the size of the hole, which means you measure, if it's a round ulcer, the diameter until you get to

the rim of relatively healthy tissue, albeit erythematous, but crater size, so to speak.

Q So roughly three of five patients who had decubitus ulcers greater than two inches in crater size had medical debridement?

A Can you just repeat that?

MR. DELBAUM: Sure.

(Record read.)

MR. FULTON: You stated before there was surgical intervention.

A I thought you said two but I would say that's correct as it stands.

Q And never had surgical debridement?

A Correct.

Q Did they heal?

A One is healing nicely over the last nine months. It is about the size of a dime. That was a heel lesion. And the other patient died before he could heal but he did not die because of his decubiti.

Q We actually had three patients that had decubitus ulcers greater than two inches who only had medical debridement. Can you think of what happened to the third one?

A Were we talking about medical debridement or surgical debridement?

Q The ones only who had medical.

A I'm sorry. The medically debrided ones are healing, all of them. The previous comments I made were with respect to the surgical debridement cases. One ended in death, not related to the d.w. There was one non-nursing home patient, which would be the sixth patient, who is healing medically and doesn't want surgical debridement.

Q Did any of those who had medical debridement of a decubitus ulcer, which was more than two inches in size, have purulence at the time of the medical debridement?

A Initially the answer would be no when the initial debridement began.

Q They did not have purulence?

A That's correct.

Q Did they develop purulence after the initial debridement began?

A I'm trying to recall. The answer would be I think there were brief periods of time in the course where they did become somewhat purulent. I would have to really look through it specifically to see, but on the balance they did very well. It might have required a brief course of antibiotics along the way or topical antibiotics, but medical debridement seemed to be successful.

Q Where were the ulcers located in the case of these three who had ulcers greater than two inches and successful

medical debridement?

A Once again, I'm trying to remember. I have had quite a few heels and malleoli, which means around the ankle, and there have been some sacral processes as well. I wish I could give you specifics. I mean, I sort of lump them together in my mind. I mean, there may even be more because some of them have been a lesser stage and they healed and I'm trying to remember. But I would say it's sacral, heel and malleoli.

Q Is it your recollection that there was one of each for these three patients? In other words, one had a sacral, one had a heel, one had an ankle, or you're not sure where they were?

A What I think about is the large ulcers that I've seen over the last year, I know for a fact I have had a couple heels, a couple malleoli, some sacral processes. I must tell you, I didn't bring those records with me to think back on them. I'm trying to give you an overview. I've seen them high and low. Some of them got fairly sizeable and of the third that I quoted to you of patients, a lot of them were in earlier stages and did very well. So I don't have as great of a recollection. Those could be anywhere from the sacrum, the greater trochanter to the buttocks. It's a whole gamut from the sacrum down.

Q With respect to the patients with sacral dicubiti, what

measures did you order to keep them off their back?

A The nursing home that I work at makes attempts to turn patients effectively and bolster them on their sides, if need be, and limit times up in their wheelchair or gerichair, depending upon the lesion. Really similar efforts as I described were done at Manor Care and would be probably done by any other nursing facility.

Q Do you have an opinion as to whether any circulatory problems that Wilbur Hofelich had probably contributed to any difficulty in his decubitus ulcer healing?

A My opinion is that I wouldn't put a circulatory component in specifically. I think he suffered from pressure ulcers because of the pressure phenomena on the coccyx, and it could happen to probably anyone in this room if you could provide enough pressure onto an area of skin over a period of time.

Q Is your answer with respect to circulatory problems any different with respect to the failure of the decubitus ulcer to get better during March or April of 1988?

A I think the fact that at times he had some granulation tissue, the fact that with surgical debridement he went on to granulate, the implication from that is that he had the potential to heal. If he had been diabetic, there might have been a contributing small vessel disease process. We didn't really identify that. And I would not invoke another

circulatory process --

Q As a problem for him?

A -- as a problem with the decubitus healing.

Q Do you read any journals of geriatric medicine regularly?

A There is a geriatric care -- we call it a throw-away, so to speak. Family Physician focuses on geriatrics somewhat. JAMA focuses occasionally an article on geriatrics but I don't read specifically geriatric journals. They are more under the scope of internal medicine, which may encompass some geriatric literature.

Q Are there any texts that you consult when you want to learn more about a geriatric medical problem?

A Well, most of us use Harrisons frequently, which is a general textbook of internal medicine. Cecils, which is another textbook of internal medicine. There are ambulatory care books.

See, a lot of my practice is ambulatory geriatrics, which is evolving on its own, so to speak, what you want to provide in terms of care in preventive medicine. And certainly neurological texts and documents if I want to refer to specific neurologic problems, which you occasionally see in the treatment of the aging. The Medical Letter.

Q Whose medical letter?

A It's called The Medical Letter, which is an assessment

of new drugs and therapies on the market, and, in fact, a recent one was just directed to the care of decubiti.

Q Who publishes that?

A I have it with me. I can give you a copy, if you would like.

Q I would love one, if counsel for the party you're involved with won't object.

MR. FULTON: As long as we all have a copy of it, I don't care. I'm easy to get along with.

MR. DELBAUM: I will stipulate to that.

MR. FULTON: Sometimes.

Q Have you had occasion to research or look at a medical text in the last year regarding the care of decubitus ulcers?

A Not a medical text per se.

Q What have you --

A I was referring to The Medical Letter. The nursing home I was working at, Menorah Park, had protocol on skin care and management. It's education that's not in a textbook.

Q Did you follow the protocols at Menorah Park while you've been associated there?

A Right. It's predominantly handled via nurses who have alerted me to problems and I've authorized them to follow

through on the stage by stage care if I was in agreement with them.

Q Do the protocols at Menorah Park deal with such things as which medical debridement agent to use?

A They are very specific. Elace is one of them. Dakin's solution is one of them. They wash wounds with Dial soap. They use A & N decubitus ointments on early stages. They have it mapped out fairly rigorously.

Q Do you know if they use a stream of normal saline solution to cleanse the wound before applying Elace when they are using Elace?

A I don't believe they do.

Q You haven't authored any articles on geriatric medicine, have you?

A No, I have not.

Q Have you authored any articles on medical legal matters?

A No, I have not.

Q Given any speeches on either of those subjects?

A No, I have not.

Q Can you tell me what your fee for this deposition is, please?

MR. FULTON: I would tell him depends who is paying for it. Since I'm paying for it, it better be lower. If you're

paying for it -- I agreed I would take care of it, didn't I?

MR. DELBAUM: No, you didn't.

MR. FULTON: Yes, I did.

MR. DELBAUM: Did you?

MR. FULTON: I certainly did. Put that off the record.

(Discussion had off the record.)

A Dependent upon the time, if we finish about noon, it will be about $500.

Q And to testify at trial?

MR. FULTON: Probably never thought about it.

A I would suspect that it will be around that. Depends. I will do it on how much time I spend.

Q What's your hourly rate?

A It would be $250.

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

MR. SEIBEL: I just want to look at his report for a second.

MR. FULTON: Off the record.

(Discussion had off the record.)

MR. SEIBEL: No questions.

MR. DELBAUM: The question of waiver

of signature?

MR. FULTON: He may want to look at it.

THE WITNESS: I want to look at it.

MR. DELBAUM: Can we agree to shorten the time since trial is Monday?

MR. FULTON: First of all, I will agree that you won't have any problem with respect to trial. In other words, he wants to read it but you can cross-examine. He can read it and make changes. There won't be a problem with you using it in court if there is no waiver.

MR. DELBAUM: The transcript will be ready tomorrow so --

MR. FULTON: You can still use it. I'm telling you, you can use it even though he hasn't had a chance to sign it, but I want him to have an opportunity to change it or something medically that's not correct and he has a right to do it.

MR. DELBAUM: That's fine.

THE WITNESS: I would like to read it, though. I will be in my office all day tomorrow and all day Friday.

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(Deposition concluded.)

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Jeffrey Adam Ross, M.D.

Computer-Aided Transcription By
CERTIFIED COURT REPORTERS

The State of Ohio,)
) ss: CERTIFICATE
County of Cuyahoga.)

I, Mary Ann Koval, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named JEFFREY ADAM ROSS, M.D. 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 him/her was by me reduced to stenotypy in the presence of said witness, afterwards transcibed upon a computer, and that the foregoing is a true and correct transcript of the testimony so given by him/her 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 Cleveland, Ohio on this 15th day of March, 1990.

Mary Ann Koval

Mary Ann Koval, hotary Public
in and for the State **of** Ohio.

My Commission expires 10-13-91.