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

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IN THE COURT OF COMMON PLEAS

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Loretta Buxton, Adminstratrix of the Estate of Beulah Willabor,

Plaintiff,

vs.

Indian Hills Nursing Center, et al,

Defendants.

Case No. 98-358-043
Kathleen S. Craig, J.

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Deposition of Robert Whitehouse, M.D., a witness herein, called by the defendants for oral examination, pursuant to the Ohio Rules of Civil Procedure, taken before Luanne K. Howe, Court Reporter and Notary Public in and for the State of Ohio, at the office of Robert Whitehouse, M.D., 36001 Euclid Avenue, Suite B-15, Willoughby, Ohio 44094, on Tuesday, April 27, 1999, commencing at 1:00 p.m.

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ROBERT WHITEHOUSE, M.D.

of lawful age, being first duly sworn, as hereinafter certified, was examined and testified as follows:

DIRECT EXAMINATION

By Mr. Mingus:

Q Dr. Whitehouse, my name is Ron Mingus, and I represent Indian Hills Nursing Center in a lawsuit that was filed by the estate of Beulah Willabor. And I'm going to be asking you some questions about your treatment of Beulah Willabor.

You've had your deposition taken before, I take it?

A Yes.

Q So you're familiar with the procedure?

A Yes.

Q Doctor, first of all, do you have any records which are separate and apart from the records which were maintained at Indian Hills Nursing Center?

A No, 1 do not.

Q And I note that you do have a copy of the Indian Hills records in front of you, and please refer to those whenever you need to to answer my questions. What was your involvement in Beulah Willabor's care?

A I took care of her from the period beginning

December 31st, 1996 through the time of her death in July of 1997.

Q And where did you take care of her at?

A At the nursing home called Indian Hills,

Q Are you an employee of Indian Hills Nursing Center?

A No.

Q From December 31st, 1996 through Mrs. Willabor's death in July of 1997, did you see her on a regular basis?

A Yes.

Q Could you tell me about her condition when Mrs. Willabor entered Indian Hills Nursing Center in December of 1996?

A Debilitated.

Q Can you tell me about any ailments, medical problems that she had at that point?

A She had something wrong with every part of her body.

Q Can you tell me about some of the ailments that she had?

A The term that's used in the medical literature to refer to her condition is called adult failure to thrive syndrome, which refers to multisystem failure, everything wearing down.

Q She was approximately 96 years old at that time?

A Yes, indeed.

Q I noted from the record she had atrial fibrillation; is that correct?
A Yes.
Q What is atrial fibrillation?
A It's an irregular heartbeat.
Q She also had congestive heart failure; is that correct?
A Yes.
Q What is congestive heart failure?
A The heart muscle is wearing out and can't pump the blood very effectively.
Q She also had Paget's disease upon her admission; is that correct?
A Yes. There are different kinds of Paget's disease. This is Paget's disease of the bone.
Q Could you describe that in Mrs. Willabor's case?
A It's a finding on the X-rays that has to do with an abnormality of the remodeling of bone.
Q She also had chronic obstructive pulmonary disease; is that correct?
A Yes.
Q What does that mean, Doctor?
A Those are changes that are like emphysema where the total lung volume goes down. The ability to move the air in and out of the lung goes down.

Q She also had X-rays which were consistent with old granulomatous disease; is that correct?
A That's correct.
Q What is that?
A She means she was exposed to TB at one time, and it's considered inactive at this point.
Q She also had coronary artery disease; is that correct?
A Right.
Q What is that?
A Hardening of the arteries, of those arteries that supply the heart muscle itself.
Q She also had atherosclerotic cardiovascular disease; is that correct?
A No. Cerebrovascular disease.
Q What is that, Doctor?
A That's hardening of the arteries in those arteries that supply the vein.
Q She also had glaucoma; is that correct?
A That diagnosis was listed on the information which came in with her into the nursing home, but I don't personally diagnose glaucoma.
Q Doctor, I see you have your chart open to a certain page. What page is that?
A It's called a "History and Physical Record."

Q Could you tell me about your history that you took when you first saw the patient?
A Yeah. As I mentioned, the term that's used to describe her overall condition is called adult failure to thrive syndrome. When physicians talk to each other about this, we sometimes use the more frivolous term, quote, total body failure, unquote. This means that she had something wrong with every part of her body, and it was globally failing.
Q Do you have any opinions as to what her future prognosis was or what her life expectancy was?
MR. CHAPMAN: At what point?
MR. MINGUS: At the time of her admission.
A At the time of her admission, her prognosis was somewhere between terrible and terminal. Her life expectancy is diminishingly small.
Q What do you mean by "diminishingly small"?
A She could die any time.
Q What other -- strike that, please.
Did she have any mental or psychological problems at the time of her initial admission?
A She had severe dementia.
Q What is that, Doctor?
A Dementia means loss of intellectual faculties.

Q Did she have any other psychological problems at that time?
A I don't think she was really tested as such for other psychiatric diagnoses like depression, anxiety.
Q I note from some of the records that she was disoriented to place, time, and situation at the time of her initial admission; is that correct, Doctor?
A You mean do I remember that, in fact, she was disoriented in that way? I don't remember, but do the records indicate that? Yes, they do,
Q Doctor, at the time of her initial admission to Indian Hills, there was an advanced directive that was signed; is that correct?
A Yes.
Q Okay. Doctor, let me hand it to you. It's been previously marked as Plaintiff's Exhibit 7. That's a copy of an advanced directive that was signed at the time of Mrs. Willabor's initial admission to Indian Hills; is that correct?
A Again, I wasn't personally there when they did this, but does this resemble the form that we use in these situations, and does it look like it's been formally signed correctly? Yes, it does.

Q That's your signature on the bottom of the advanced directive?
A Yes.
Q What is an advanced directive?
A It's a directive on the part of the patient or their guardian stating what level of aggressiveness is to be undertaken should the patient's condition deteriorate.
Q And what did the advanced directive in Mrs. Willabor's case provide?
A The advanced directive states that we are not to pound on the patient's chest or intubate her, or place a tube through her nose into the stomach to feed her.
Q And that advanced directive is purportedly signed by Mrs. Willabor's daughter, Loretta Buxton; is that correct?
A Anybody's guess on this one. I wouldn't go out on a limb to say what that signature says there. (Indicating.)
Q When a patient's family signs an advanced directive which prohibits the use of a feeding tube, how does that affect the way that you can take care of a patient's nutritional status?
MR. CHAPMAN: Objection. Go ahead.

A What it means is that we don't put a tube down to feed the patient.

Q In a situation where a patient is refusing to eat, does an advanced directive which prohibits the use of a feeding tube limit your options in terms of taking care of a patient's nutritional status?

A Yes.

Q In what way?

A Just in the obvious, specific way we've already talked about, that you can't put a feeding tube down.

Q If a patient refuses to eat and the family prohibits the use of a feeding tube, are there any long-term ways in which you can take care of a patient's nutritional status?

A There's something called TPN, which means total parenteral nutrition, where you can place a central line in the chest cavity and put proteins and lipids and the equivalent of sugar water and electrolytes through the tube. This is not done in nursing homes. It's only done in intensive care units in the hospital.

Q Is that a more extreme measure than the use of a feeding tube?

A Much more extreme.

Q Did you have any discussions with Mrs. Willabor's family about the use of a feeding tube?
A Yes, I did.
Q Could you tell me about those, please?
A Well, my note of February 13th, 1997 states that I did talk to the family and that they requested no further aggressive interventions.
Q Is it your practice to talk with the patient's family about the use of a feeding tube in cases where a patient is not eating?
A I have the conversation three to four times a day with different families.
Q Could you tell me how that conversation usually goes?

MR. CHAPMAN: Objection. Go ahead.

A The conversation goes something like this: I'm calling you about your mother or I'm talking to about your mother or your dad, who's not eating well and not taking enough fluids to sustain themselves. Our choices are to let things keep going the way they are, in which case, they could starve or dehydrate, or to sustain them with some type of artificial nutrition and hydration. That could include intervenous fluids. It could include passing a tube down the nose into the stomach. It

can include placing an opening through the abdominal wall into the stomach and feeding through the tube that way.

Q On February 13th, did you discuss with Mrs. Willabor's family the fact that she was not eating?

MR. CHAPMAN: Objection. Asked and answered.

A Okay. I have the conversation three to four times a day with different family members, and this goes back to 1997, so absolutely, positively I do not remember, but, again, my note states that it was discussed with the family and quote -- from my own notes, quote, no further aggressive interventions, unquote.

Q Did you have any other discussions with the family about Mrs. Willabor not eating and the use of a feeding tube?

A Again, I don't remember because it's something that I do many times in a day. There's nothing in my progress notes indicating that I did or did not. I might add that it's very common for me to have these conversations with family members here in the office when I don't have access to the patient's chart, which is at the nursing home, so I have a lot of

those kinds of conversations that don't get carried over or written down into the patient's chart in the nursing home because this is happening at two different locations.

Q Other than yourself, are there other physicians who see patients at Indian Hills Nursing Center?

A Yes.

Q I want to talk to you about some of Mrs. Willabor's other medical problems at the time of her initial admission. She also had bronchitis at the time of her initial admission; is that correct? Let me reask the question, Doctor.

A Yes, that's correct.

Q Could you read for me your history and physical records which you took on December 31st, 1996?

A Chief complaint: Failure to thrive. History of present illness: Patient is demented, living at home with her daughter, increased confusion, inanition, i-n-a-n-i-t-i-o-n, decreased intake, malnutrition, admitted for evaluation. That usually means admitted to the hospital for evaluation. And now here for rehab, meaning here at the nursing home.

Review of systems: Patient unable to give me meaningful information, depression, dementia,

congestive heart failure, arteriosclerotic heart disease, arteriosclerotic cerebrovascular disease, chronic atrial fibrillation, peripheral vascular disease, osteoporosis, degenerative arthritis, Paget's disease of the bone, anemia, hypertension, bronchitis, folate deficiency, left ventricle hypertrophy, glaucoma, old heart attack per EKG, right lung nodule, early decubiti, cholelithiasis, electrolyte imbalance, multiple nonspecific laboratory abnormalities. Other per attached, meaning records from the hospital.

Q What is early decubiti?

A Bedsores.

Q She had bedsores at the time of her initial admission?

A According to my notes.

Q That was located on the scapula?

A Both scapulae.

Q Where is the scapula located?

A Back here. (Indicating.)

Q You're pointing to the shoulder blade area?

A Superior-posterior thoracic area.

Q Your history also indicates a right lung nodule?

A Correct.

Q What was that, Doctor?

A It was never ultimately diagnosed. The patient was seen by a specialist, who is Dr. Epstein, who said if we were to evaluate it, the patient would need a CAT scan of the chest. And, again, after some discussion with Dr. Epstein and/or the family, we decided that we wouldn't do anything about whatever it was anyhow given her other multiple medical problems. So it was ultimately decided not to get the CAT scan of the chest.

Q What is folate deficiency?

A Folate is one of the B vitamins. It's in your diet. Almost all folic deficiency in the United States is due to malnutrition.

Q Did she have signs of malnutrition at the time of her initial admission?

A Yes.

Q Could you tell me about those, Doctor?

A Well, you're mostly talking about how the patient appears clinically, meaning that they look thin. They look malnourished. They look chronically ill. There are also some chemical indices that we use like serum albumin and some vitamin levels, calcium levels, and so on that are markers for nutrition.

Q Would you describe her as being cachectic at the time of her initial admission?

A My notes don't show cachexia as such, so I'd have to see a photograph of the patient before I could answer that.

Q Doctor, was she taking any medication at the time of her initial admission?

A I'm sure she was, and that would be on the medication list, which I don't actually have here. I'm sorry. We do have it. It's about a page and a half of medications.

Q Could you tell me what she was taking and what she was taking it for?

A Yes. She was on a folate supplement, which is a vitamin supplement. She was on one baby aspirin a day to help thin the blood out. She was on an antidepressant called Zoloft. She was on a nitroglycerin patch, which we use for coronary artery disease. She was on a medicine called Digoxin, which we use to regulate the heart beat. She was on Lisinopril, which is a medication we use for more than one thing. Probably in her case, it was being used for the congestive heart failure and possibly for hypertension.

She was on an inhaler to help keep her breathing tubes open. She was on nutritional supplements three times a day and a medicine as

needed for constipation. Also, at one point, she was on an antibiotic, and at one point, she was on a medicine called Lasix, which is a diuretic we use for heart failure.

Q Did you place her on Lasix during her stay?

A She was on Lasix when she came in, I believe. To be honest, I can't read about half of it. It's just a poor quality copy, but it would make sense that she probably was on Lasix when she came in, which is one of the medicines they use for treating heart failure.

Q Doctor, I'd like to refer you to your physician's orders. Do you have those in front of you?

A Yes. Okay, yeah. Here, I can clarify this for you. The date is cut off on this, but, actually, January 21st of '97, the patient was started on Lasix for some swelling of her lower extremities.

Q I note from your order of January 27th of 1997 that you started her on Rocephin; is that correct?

A Yes.

Q What is Rocephin?

A It's an antibiotic.

Q And on your order immediately before that dated January 28th, 1997, Mrs. Willabor was transferred to Room 404-A; is that correct?

A I don't know. That's something you'd have to glean from the nurses' notes. Yes. Yes, indeed.
Q 404-A, is that on the intermediate care floor?
A You have to ask the nurses about that. I don't know.
Q When you first started seeing Mrs. Willabor, was she in skilled care at Indian Hills?
A You'd have to tell me the room number.
Q The 500 hall.
A 500 hall is the skilled hall.
Q Was she in the skilled hall?
A You mean do I remember physically seeing her on the skilled hall? No, I don't. But if the records indicate she was on the skilled hall, then she was.
Q At least the records indicate she was initially on the skilled hall?
A Again, you have to -- in the records as they're kept by the physician, the room number isn't actually written down here.
Q Okay. It was your order on January 28th to transfer her to Room 404-A?
A Okay.
Q And let me represent to you that Room 404-A is on the intermediate hall.
A Okay.

Q Do you recall why it was that she had been transferred to the intermediate hall?
A Well, patients hit a plateau on the skilled floor, and all the team members involved in taking care of a patient make a recommendation to the physician that the patient is not going to get any better or benefit any further from ongoing high-intensity care and that it's appropriate to transfer them to a lower intensity of care for maintenance.
Q A feeding tube was never used for Mrs. Willabor, correct?
A Well, again, I don't remember, but if one looks at the records, I don't see any indication in here that a feeding tube was ever ordered for the patient.
Q Did you monitor Mrs. Willabor's weight throughout her admission at Indian Hills?
A The weight is routinely monitored on all patients in the nursing home including presumably this patient,
Q Okay. I take it, as your patient, you would have been involved in helping to monitor Mrs. Willabor's weight?
A Yes. The physician doesn't physically weigh the patient or necessarily review the weight records, but there's a protocol in place at all nursing homes if the patient's weight goes above or below certain

parameters within a certain period of time, the physician is to be notified. And I don't know those specific parameters for this specific nursing home, but they can tell you that.

Q Are you aware of Mrs. Willabor sustaining any drastic loss in weight while she was at the nursing home?

A You'd have to consult the weight records to document that, but just looking over the notes, I'm going to guess that she probably did lose weight because my notes say she's not eating and not taking fluids well, so it would be surprising if she didn't lose weight.

Q I take it it's to be expected when a patient doesn't eat that the patient will lose weight?

A Exactly.

Q What steps did you do -- strike that.

What steps did you take as Mrs. Willabor's physician to see to it that she was receiving proper nutrition?

A Well, again, this is embedded in the system that takes care of the patient, which includes monitoring of weight, ongoing nursing care. If appropriate, ongoing laboratory monitoring.

Q Nutritional supplements, were those ordered for the

patient?

A Yes. Three times a day.

Q Given Mrs. Willabor's --

A Also, may I add also, as mentioned previously, she was on a folate supplement.

Q What else was done to help Mrs. Willabor receive the proper amount of nutrition?

A Well, that, again, just falls within the domain of the nursing care. If you have a patient who's very slow to eat or doesn't like to eat, you assign people to spend whatever time is necessary to try to get the patient to eat. You sit with them. Sometimes you have the nutritionist, you know, try different types of foods. Sometimes we have a speech therapist see the patient to see if there's a problem of swallowing, so it's different for each patient.

And, again, on this particular patient, I don't know specifically what was done. You'd have to consult the nursing records and nutritionist's notes and if there's a special therapy note. You'd have to look at those notes.

Q Do you have any criticisms of the nursing care that was administered to Mrs. Willabor?

A Not off the top of my head, but you have to break it

down into specifics because the statement is so broad.

Q Doctor, I'd like to take you back to your physician's notes, if you could take me through those, please. First of all, starting with your December 31st, 1996 note --

MR. CHAPMAN: Excuse me. I'm not sure I'm referring to the same thing you are. Is that marked as an exhibit?

MR. MINGUS: No.

THE WITNESS: Do you want to see it?

MR. CHAPMAN: Can I get a quick copy?

THE WITNESS: How about if I do this. We've got a copy machine here, but in order to answer his question, I have to have this.

MR. CRANDALL: Do you want a copy of all of them? You don't have any of them?

MR. CHAPMAN: I have them somewhere. For some reason, they are not in my exhibit notebook.

THE WITNESS: Can I answer his question first?

MR. CHAPMAN: Yeah, why don't you do that, and we can go off the record for a minute.

A Coming back to your question now, on

December 31st of 1996, my entry says, "Per the history and physical --" that means refer to the page that we previously discussed called the "History and Physical Records," and then in quotes it says, "partial measures," unquote. What that is is a clarification of what the patient's advanced directive is, and in this case, it's not, quote, full measures, which means do everything possible. And it's not, quote, an actual DNR, which means don't do any aggressive measures. It was kind of in the gray area in between as specified on the advanced directive, which we've already discussed as well in some detail, so that's what that entry refers to. Shall I keep going?

Q Well, why don't we stop, and you can get John a COPY.

MR. CHAPMAN: Thank you.

(Discussion off the record.)

Q Why don't you walk me through your January 18th, 1997 progress note?

A Sure. The progress note of January 18th of 1997 states that the patient didn't have any apparent complaints. She was confused, but pleasant. Her temperature was okay. Her vital signs were okay. She was not eating well.

Lab work was reviewed and was found to be okay at that time. The chest X-ray showed the chronic granulomatous disease, which we already referred to, which in my opinion does not need treatment, as my note states, and that we were monitoring blood levels of some of the medicines.

Q Why did her chronic granulomatous disease not require treatment?

A The reason in this patient why you would not treat this is because it's old. It just refers to the patient having been exposed at one time to TB, and it's not active.

Q Could you go on to your February 13th note, please?

A Yes. This is the note we referred to previously. The patient continues to globally decline. I discussed with family. No further aggressive interventions. Multiple lab abnormalities now, which are consistent with dehydration and her poor intake, which is to be expected, of course.

Q What ways are there to treat dehydration?

A We've already discussed that before. It includes passing a tube down from the nose into the stomach, creating an opening in the abdominal wall and passing a tube through there and feeding through that tube, intravenous fluids, and then the

previously mentioned TPN, total parenteral nutrition, involving the placing of a central line in the chest cavity.

Q And can you tell me why none of those particular measures were taken to treat her dehydration?

A Because I discussed it with the family, and they didn't want anything further done. I might add that intravenous fluids are not a permanent solution. You could use those for a few days, but you can't keep IVs in forever. They have to be changed every three days so that the lines don't become infected.

Q What would be the permanent solution or the more long-term solution to treating dehydration? Would that be the feeding tube?

A The feeding tube, yes. And even the tube that goes from the nose into the stomach is not considered permanent. You can use that up to a month or two, but that causes complications too, so the only permanent one would be the tube that goes right through the abdominal wall into the stomach, which is called a PEG tube, P-E-G.

Q I take it then, Doctor, that you determined that using intravenous fluids would not have been a solution to Mrs. Willabor's dehydration problems?

A It would have been a short-term solution -- or shall

we say like putting a finger in the dike type of solution, but it wouldn't solve the underlying problem.

Q And was that the reason why no intravenous fluids were administered to Mrs. Willabor after this time, which was February 13th?

MR. CHAPMAN: Objection.

A The answer is I can't remember because, as I mentioned previously, I have this conversation three or four times a day with different family members, and to ask about a conversation like this in 1997, it's impossible to remember. But I can answer it indirectly. If the family had decided they wanted an IV, an IV would have been placed, if their response had been they wanted an IV.

Q On February 13th, when you talked with the family, would you have discussed with them the option of using intravenous fluids for Mrs. Willabor's dehydration problems?

MR. CHAPMAN: Objection.

A The answer to the question is yes, although let me caution that even though this entry is made on February 13th, again, more often than not, this conversation was actually probably held at a different place and time, and this was my first

chance to document it in the patient record when I was there in the nursing home. So let us not make the assumption that I was at the nursing home on February 13th having the conversation with the family at that time because that would be the exception rather than the rule.

Q But based upon your February 13th note, would it be fair to say that you would have discussed with Mrs. Willabor's family the option of intravenous fluids being used for dehydration?

A Yes.

MR. CHAPMAN: Objection.

A Absolutely. That would be routine.

Q Could you please read your March 6th note, please, Doctor?

A It says, "Patient is resting comfortably in bed. She has a coccyx," referring to the tailbone area, "which is being treated at that time. Her temperature is okay. Her vital signs are okay. She continues to decline overall, and again multiple lab abnormalities are noted." And now it says, "Comfort measures only."

Q What did you mean by "comfort measures only"?

A This is a concept similar to that which you see with hospice patients where you agree the patient is not

going to get better and you're not going to do a lot of aggressive interventions and run around and do a lot of tests or subject the patient to a lot of procedures, and you just go for comfort measures.

Q When a patient is given comfort measures only, what sort of treatment would that rule out that you would not perform?

A You would not pound on their chest if their heart stopped. You would not hook them up to a ventilator. You would not stick tubes in various orifices, including feeding tubes. You would not do surgery. You would not subject the patient to any tests that would give you results that wouldn't change what you would do with the patient.

Q Do you have any opinions as to why her overall condition continued to decline?

MR. CHAPMAN: Objection.

A Yes. The patient is 96 years old and has -- as I mentioned in a somewhat jocular manner earlier, she's suffering from total body failure.

Q Do you believe it was inevitable that her overall condition would continue to decline?

MR. CHAPMAN: Objection.

A Yes, I do.

Q Is that to a reasonable degree of medical certainty

that you hold that opinion?

MR. CHAPMAN: Objection.

A Yes, I do.

Q Could you please read your -- what looks to be a March 28th note?

A Yes. "At this point, the patient is developing more and more decubiti," which are bedsores, "which is not healing." And I'm writing my opinion that it's because of hardening of the arteries as opposed to negligent nursing care.

Q Mrs. Willabor did have some sores that developed during her admission; is that correct?,

A Yes.

Q And do you have an opinion as to the cause of those sores?

MR. CHAPMAN: Objection.

A As I just stated, because of hardening of the arteries, which is here listed as peripheral vascular disease, and that in combination with her bed-bound status and poor nutrition.

Q I believe you said that in your opinion, the sores were not the result of improper nursing care; is that fair?

A That's correct.

Q And is that your opinion to a reasonable degree of

medical certainty?

MR. CHAPMAN: Objection.

A Yes, it is.

Q Could you read your March 24th note, please, Doctor -- I'm sorry -- your April 24th note?

A At this point, the patient was evaluated in some way by Dr. Epstein, who as I mentioned previously is the lung specialist, and who at that point had said a CAT scan of the chest would have to be done to evaluate the nodule, so my note indicates CAT scan of chest pending, meaning further pulmonary follow-up.

Q Do you know if the CAT scan of the chest was ever taken?

A As my notes indicate -- again, I'm reading between the lines here, it was eventually decided not to do the CAT scan for the reason we talked about previously, which is that the patient was to be comfort measures only, so even if we did the CAT scan and it was abnormal, it would give us information that wouldn't change what we would do with the patient.

Q Doctor, could you read your next note, please?

A Yeah. In fact, that's what the next note says, "Do not feel CAT scan of the chest should be pursued

further." And my memory of this is that I talked to Dr. Epstein during that time, and that was what we decided between the two of us. And I think we have a note from Dr. Epstein somewhere that probably indicates that. And at that point too, we're doing cultures on the wounds to see what kind of bugs grow out.

Q Did you refer Mrs. Willabor to Dr. Epstein?

A Yeah. Dr. Epstein's note is from May 6th of 1997. And at that point too, she had pneumonia.

Would it be appropriate for me to quote from his notes?

Q Sure.

A Quote, "In view of general health and age, do not feel FOB is warranted." There's another word I can't read. "Evaluate with diagnostic workup as above." And I do recall talking to Dr. Epstein at this time since I see him almost every day, and I'm 99 percent sure that our mutual decision was that we shouldn't, as we say, "drag this lady through any more tests," unquote, is how we would have said it to each other because it wouldn't change our management.

Q Could you read your next note, please, Doctor?

A We are up to June now. "Ongoing RX," meaning

treatment, "to various areas per nursing notes." This refers to the patient's multiple bedsores, and at this point, I discussed with Dr. Niemczura, who's a vascular specialist, to see if anything could be done to improve the blood supply to these areas that aren't healing. And, in fact, Dr. Niemczura's note is dated nine days previous to that, so he had obviously seen her in the meantime.

And, again, would it be appropriate for me to quote from Dr. Niemczura's notes?

Q Sure.

A In essence, what the note says is the patient has no blood supply to any of these areas and they are not going to heal, and he's recommending amputation. And, again, it's very likely I talked to Dr. Niemczura personally at the time because that's my practice to do that.

MR. CHAPMAN: Objection.

A And we agreed that she was never going to get better.

Q What role did the lack of blood supply have in the development of Mrs. Willabor's sores?

MR. CHAPMAN: Objection.

A Major.

Q Could you explain, please?

A Any part of the body that doesn't get a blood supply dies, including areas of skin, which is called a bedsore.
Q Mrs. Willabor had sores on her right foot and ankle; is that correct?
A I'd have to look -- I know she had multiple decubiti. In fact, I've got pictures here, and the pictures are labeled as right foot. Yes, right foot and ankle, but also the right scalp.
Q To a reasonable degree of medical certainty, is it your opinion that the lack of blood supply was a cause of sores on Mrs. Willabor's right foot and ankle?
MR. CHAPMAN: Objection.
A It was a major cause. And also the right buttocks is listed too, so the scalp, the buttocks, right foot, right ankle. She had multiple sites.
Q What was done to treat Mrs. Willabor's sores?
A She was receiving ongoing topical treatment of one sort or another and also antibiotics intermittently.
Q What do you mean by topical treatment?
A This is one where you have to consult the nursing notes to see what she was getting, and probably she was getting different treatments to different sites at different times. I can tell you the types of

things that we do to treat these in general.

Q Sure. What sort of things do you do to treat sores?

A Sometimes we use dry dressings, just keep the area clean and dry. Sometimes we use what we call wet to dry dressings, which is applying a wet dressing, letting it dry out and pull it off. We use various topical antibiotics, including Bacitracin and Bactroban and other different topical antibiotics that we use. There are other preparations like Duoderm, which are put on for 48 to 72 hours and then removed and artificial skin and things like that. But, again, you'd have to consult the nursing notes for the specifics of what was done on this patient.

Q Would you take a look at your orders and tell me whether you ordered anything to be done to take care of Mrs. Willabor's sores?

A Okay. There's a special mattress called a Geo-Mattress, which is designed to take pressure off of bony prominences. There's something called a Spanco boot, which, again, is just a device designed to take pressure off of, in this case, the heel. Patient was receiving nutritional supplements, folate supplements.

What else? She was on antibiotics

intermittently. When her lower extremities were swollen, on one occasion, we used some special elastic stockings that are called surgical stockings. And here are some dry dressings. Here are some normal saline dressings, Here's a product called Duoderm, which is the one I mentioned that you put over the open area and remove every 72 hours. Here are some saline irrigations, some more antibiotics. And there are some here I just can't read.

Q Those are all measures which you ordered to take care of Mrs. Willabor's wounds?

a Right. Here's another one calle(Dakins so ution, which is sometimes used, D-a-k-i-n-s.

a Do you have any opinions as to whether or not Mrs. Willabor's sores were avoidable or unavoidable?

a It's an ultimately unanswerable question, but I believe that all reasonable measures were taken in this patient to avoid them.

MR. CHAPMAN: Objection.

A Now, I will add if the patient had received a feeding tube in here, this would not have progressed as rapidly as it did, but the family decided against the feeding tube.

Q How common is it for patients at nursing homes to

receive feeding tubes?
A I don't know the answer to that question. If you can be a little bit more specific, I can maybe answer it.
Q For your patients at nursing homes, how common is it for them to receive feeding tubes --
MR. CHAPMAN: Objection.
Q -- when they are not eating?
A I will tell you the majority of the time, the family decides against the feeding tube. But a significant minority of the time, they do ask for a feeding tube, but I can't give you a number. Did I answer your question?
Q Yes. Do persons have a tendency to bruise more easily as they get older?
A Yes.
Q Why is that?
A It's a really long story. Really, it is. It has to do with the fact that there's less fat under your skin to cushion you. There's a redistribution of fat from the extremities to the central part of the body. There's an increased tendency to fall down and bang yourself, to be less coordinated. Balance -- when you get up too quickly out of a chair or out of bed, you don't get as good a blood

supply to your head.
Q As a 96-year-old woman, do you believe Mrs. Willabor had a greater tendency to bruise than perhaps people of younger age?
A Of course.
MR. CHAPMAN: Objection.
Q Are you aware of any improper actions of anyone at Indian Hills Nursing Center which led to any bruises in Mrs. Willabor?
MR. CHAPMAN: Objection.
A Nothing that was ever called to my attention.
MR. MINGUS: I'm going to take a little break here. Doctor, I think I'm just about done.
(Recess taken.)
By Mr. Mingus:
Q Doctor, do you believe Mrs. Willabor had anything about her that made her more prone to falling down than other people?
A All the things we've talked about since we started here today, advanced age, frailty, inanition.
Q Are you aware of any staff at Indian Hills doing anything negligent in terms of doing what they could to prevent Mrs. Willabor from falling?
MR. CHAPMAN: Objection. *Go* ahead.

A I don't know how to answer the question because I don't know what the legal definition of "negligent" is. I assume -- that's not a medical word. It's a legal word, and I don't know what it means.

Q Okay. Do you have any opinions as to whether or not anything else could have been done to prevent -- let me rephrase that. Why do you believe Mrs. Willabor was more prone to fall than perhaps other people?

MR. CHAPMAN: Objection.

A Just what I just said. You know, just advanced age, frailty, total body failure.

MR. MINGUS: Doctor, I don't have anything else for you right now. Thank you very much for your time.

CROSS-EXAMINATION

By Mr. Chapman:

Q Doctor, my name is John Chapman. I'm the attorney along with Cal Hurd, the gentleman to my left, the attorney for the Beulah Willabor family. I have some questions for you as well.

A Sure.

Q Before coming to today's deposition, sir, did you review any papers?

A Wherever **I** got this pile of papers from was reviewed by me.

Q Okay. And that comprises the complete chart?
A (Indicating.)
Q You're pointing out two additional documents to me. So there's a notebook in front of you, and you reviewed that prior to today. You also reviewed those photographs. And what's the other document?
A The document is not labeled. My guess is that this is copies of the nursing notes.
Q May I see it, please?
A (Witness complies.) Since it's about half legible, I'm not completely sure.
Q Doctor, during your testimony, you referred to notes from Dr. Niemczura?
A Niemczura.
Q Niemczura?
A Yes.
Q And also Dr. Epstein?
A Yes.
Q Could you point those out to me?
A I'm holding them in my hand right now.
Q May I see those two pages, please?
A (Witness complies.)
Q Thank you. Doctor, you're a medical doctor?
A Yes.
Q Where did you get your license?

A University of Wisconsin.
Q When?
A I'm sorry. When you say "license," do you mean my medical degree?
Q Yes.
A Graduated in 1974.
Q Okay. Are you board certified in any area?
A I'm board certified in family practice, and I have a fellowship in geriatrics.
Q Would you basically describe for me your current practice?
A Solo family practice with an emphasis on geriatrics.
Q How long have you practiced in that fashion?
MR. CRANDALL: Go ahead and answer the question, then make copies.
A How long have I been in practice?
Q How long have you been a solo family practitioner with an emphasis in geriatrics?
A Intermittently since 1977.
Q Do you have staff privileges at any hospitals?
A Yes. Lake Hospital Systems East, Lake Hospital Systems West, Laurelwood, Mount Sinai East, Meridia Euclid, Hospice House, and teaching staff at Case Western.
Q Did you talk to anybody other than your attorney in

preparation for today's deposition?
A No. You know what? I did get a phone call from -- can you excuse me for one second? Let me get another piece of paper.
(Witness was temporarily excused.)
A I actually got a letter from -- I said phone call. That was incorrect. A letter from Loretta Buxton that was dated March 22nd, and I did call her back to address the concerns in the letter. (Indicating.)
Q My question was whether or not you talked with anybody other than your attorney, who's here today, about --
A Yeah, I spoke with Loretta Buxton.
Q You spoke with Miss Buxton. What did you discuss with Miss Buxton?
A Boy, I would have addressed whatever she is asking about in her letter. And, basically, the letter says, would you talk to Mr. Chapman.
Q Is that what you discussed with her?
A Yes.
Q How did you respond to that question?
A I said that we had already set up an interview to talk to somebody, and then I received a phone call from somebody else saying, no, no, no, don't talk to

that person without having lawyers representing you present -- I'm paraphrasing -- something on that order.

Q So lawyers are pretty much telling you you're sort of a pawn in all of this?

A Yeah. I'm getting moved back and forth from one side of the board to another.

Q Have you been asked to serve as an expert witness in the litigation that's going on between the Willabor family and Indian Hills?

A If you actually read the substance of Ms. Buxton's letter, essentially, it looks like that's what she's asking me to do, but did I agree that I would do that with her? No, I didn't.

MR. MINGUS: Could I see that letter and get a copy of that?

MR. CRANDALL: 1'11 pass it to you.

MR. CHAPMAN: Okay. Thanks.

Q Prior to today's deposition, did you review the reports of any medical experts or nursing experts?

A You mean have I looked at anything outside of these documents in front of me?

Q Right.

A No, I haven't. But the documents in front of me contain what we call a consult, the consultant's

notes from Dr. Epstein and Dr. Niemczura.

Q I think you testified in response to one of Mr. Mingus's questions that you began treating Mrs. Willabor while she was at Indian Hills, correct?

A Correct.

Q And your notes reflect that she would have become a resident at Indian Hills sometime in the very end of December of 1996?

A My first note is December 31st of 1996.

Q Now, did you have a relationship with Mrs. Willabor prior to December 31st --

A Not that **I** know of.

Q One of the keys to deposition testimony is if you let me finish my question and then give an answer, we'll get both question and answer down and get a clean transcript.

Did you have any kind of a relationship with the Willabor family or with Mrs. Willabor prior to December 31st of 1996?

A Not that I know of,

Q How was it that you came to become Mrs. Willabor's physician?

A There's some process by which the admissions people at the nursing home assign incoming patients to

physicians on the staff. I don't know what the process is.

Q So then you are on the staff at Indian Hills?

MR. MINGUS: Objection.

A Correct.

Q How long have you been on the staff at Indian Hills?

MR. MINGUS: Objection. Go ahead.

A Since the mid-1980s.

Q So it's fair to say then that it was not a matter of the Willabor family or Mrs. Willabor meeting with you to determine whether or not you would be their physician?

A That sometimes happens, and I cannot tell you that that did or did not happen with this particular patient. The information probably would be on the intake sheet, though.

Q As you sit here today, Doctor, do you recall any specific conversation that you ever had with Beulah Willabor other than the one that you just referenced?

A Do you mean with Miss Buxton?

Q With Miss Buxton.

THE WITNESS: I'm sorry. Can I see the letter again?

MR. MINGUS: Yes.

A Going back to my progress note of February 13th, it says, "discussed with family." Okay. It's not stated who that is. It's likely that that was Loretta Buxton, but it could have been somebody else.

Q Other than that conversation that you noted, you don't specifically remember that conversation?

A No. As I mentioned, it's a conversation I have three or four times a day with different family members, so there's no way I would remember that.

Q Do you recall or have you found in the notes that you reviewed prior *to* today's deposition any other conversations with any member of the Willabor family?

A Do I recall any? No.

Q And you see no reference to any other conversations with anybody in the Willabor family?

A That's correct.

Q Now, is it your practice to maintain a file here in your office for patients whose care has been assigned to you that are staying at Indian Hills?

A No, it is not.

a Can you describe for me then the mechanism by which you maintain a chart or records for your care of the residents who are at Indian Hills?

A Yes. It's called the chart, and it's at the nursing home. And I'm holding a copy or what is alleged to be a complete copy of the patient's chart in my hands at this time. (Indicating.)

Q So did you make entries into the charts at Indian Hills during visits to Indian Hills?

A The answer is it's done differently on different patients at different times depending on what's happening. But in general, every patient would have a monthly progress note. If there's something else going on above and beyond the average monthly visit, then additional notes are made.

And by the way, the documentation of conversations with physician and family members also occurs in the nursing notes and sometimes in the social service notes and other places too, so I'm referring now strictly to the physician progress notes.

Q If Mrs. Willabor or a member of her family wanted to contact you regarding the care that Mrs. Willabor was receiving at Indian Hills, what would be the normal mechanism for them to get in touch with you?

A Call the office, Now, sometimes family members will leave messages actually at the nursing home. There's a folder for each physician on each one of

the nursing units. And I go to the nursing home three times a week, and I check each folder on each nursing unit. And I make sure it's clean by the time I leave. Occasionally, you'll have a message in the folder saying the family of so and so wants to talk to you about their mother or whatever.

Q Is it your practice to wear a white coat when you're making the rounds at Indian Hills?

A I never wear a white coat. It's scares the patients.

Q Now, from time to time, do you call -- I think you indicated that you called upon physicians in other specialties --

A That's correct.

Q -- to assist you when a particular problem came up?

A That's correct.

Q And you referenced already Dr. Epstein and Dr. --

A Niemczura.

Q -- Niemczura. Are Dr. Epstein and Dr. Niemczura also on staff at Indian Hills?

A Not that I know of. It's very unusual to have a specialist come into nursing homes. It happens occasionally.

Q Why is that?

A They just don't do it.

Q You can't get them to come in?
A That's correct.
Q Why are they reluctant to come in?
A You'd have to ask them that.
Q What is this specialty that you have in -- it's family medicine and geriatrics. Are you essentially an internist?
A No. There are two separate things. One is -- I did a three-year residency in family practice, and I'm board certified in family practice. Our organization is the American Academy of Family Physicians, so I'm a fellow of the AAFP. I'm board certified in family practice.

As a separate specialty, I have a fellowship in geriatrics, and I'm, therefore, also a fellow of the American Geriatric Society. So that makes me a FAGS, **F-A-G-S,** and a FAAFP, F-A-A-F-P. They are separate fellowships, though.

Q Okay. Is a specialty in geriatrics -- exactly what is it that you're able to do? Is it diagnosing infirmities of the aged, or can you treat a wide variety of infirmities of the aged?
A That's correct.
Q Do you have staff privileges at any nursing homes other than Indian Hills?

A 25. It's actually more.
Q How many patients do you have who are residents in nursing homes at any given time?
A I think it's in the hundreds. I don't know the exact number. My billing lady could give you an up-to-date, exact number.
Q So you visit 25 nursing homes three times a week?
A No. The nursing homes that I visit three times a week are just my real busy, larger nursing homes because there's so much work to do. I have to go in three times a week to get all the work done. But other nursing homes, I may only have one or two patients. I go in once a month and just as needed if they get sick or something.
Q Doctor, I served a subpoena on you at the end of last week requesting that you produce certain documents that I could refer to during the deposition. One of them was any documents that evidence, relate, or pertain in any way to the manner in which Beulah Willabor's medical care was assigned or referred to you. Do you remember that request?
A As you're reading it now, yes.
Q Okay. Do you possess any such documents?
A The only documents I know of relevant to this

patient's case are sitting right here in front of me right now.

Q So the answer is if they're not in the file, then there is nothing indicating how you came to be the physician for Beulah Willabor?

A That's correct.

Q Who at Indian Hills would know whether or not Beulah Willabor's care was assigned to you? Who assigns residents to be cared for by you?

A The admitting office.

Q Who at the admitting office?

A There's been a turnover of people in the admitting office, and I'm almost positive that whoever was there in early 1997 is different than whoever is there right now. And if you said a name, I might be able to remember that's who it was, but I can't tell you.

Q But you did not receive a paper from Indian Hills that says you are now the physician in charge of Beulah Willabor?

A That's correct, there's no such paper.

Q This information is given to you over the phone?

A Right, exactly.

Q Another request that I had was a listing of nursing homes where you were affiliated or on staff.

A Yeah, we can give you a list of that. It's quite long. And also my curriculum vitae, which is over three pages long, is not up to date, but we can give you what we have. I don't know where it is. It's here somewhere.

Q So then I take it you have not assembled the things that comply with the subpoena?

A That's right. I wish we had grabbed Anita before she left the office because she could have gotten that stuff for you. I apologize, but we can get it for you.

Q There's another request for documents that relate in any way to any business, professional, or contractual relationship between yourself and, first of all, a company called Integrated Health Services, Inc.

A There are no documents.

Q Indian Hills Nursing Center?

A There are no documents.

Q Health Care Corporation?

A There are no documents.

Q I also requested billing records including Medicare, Medicaid records.

A Yes. And, again, we can get that for you. My billing lady is gone for the day, but we can get

those.

Q Do you typically provide residents who are placed under your care with a calling card?

A The answer is that I do if the patient is alert enough to be able to use the information,

Q Do you know whether or not you provided Mr. Willabor with a calling card?

A No, I don't.

Q Have you ever served as an expert witness in any kind of litigation before?

A No.

Q Have you ever --

A May I clarify? I don't consider myself functioning as an expert witness right now. I'm functioning as a material witness. That's my opinion.

Q Have you ever been a defendant in a lawsuit in which you were alleged to have committed malpractice?

MR. MINGUS: Objection.

MR. CRANDALL: Objection. Go ahead and answer.

A I don't know. We've got -- there's a total of three cases, and I'm not completely sure -- can I ask a question off the record? I can answer your question better if you can answer something for me.

Q Sure. But so the record is clear, you can just kind

of ignore the fact she's taking this down.

A A couple years ago, for example, there was a patient at another nursing home where they sued over **30** people involved in the patient's care, and they named everybody. And I was on that list, but I was dropped, so I don't know what you call something like that. And there was another one that is a current right now where I was listed along with a zillion other people. Probably nothing is going to come of it, so I don't know if that is included in the question that you asked me. If it is, then the answer is yes.

Q You can think of those two instances?

A As the kind of thing that you have in mind?

Q Right.

A Then the answer is yes.

Q So there's been two to your knowledge?

MR. MINGUS: Objection.

A Yes. I can't give the correct number. I'd have to look through my file.

Q More than two?

MR. MINGUS: Objection.

A Possibly, yeah.

Q The period of time that I want to focus in on, Dr. Whitehouse, is the period of time during which

Beulah Willabor was a resident at Indian Hills, and we established that that was sometime towards the very end of December 1996, and we have also established that she died in July of 1997. So do you have that period of time in mind?

A I sure do.

Q Okay. Is it your testimony that you made rounds at Indian Hills about three times a week?

A Yes, absolutely.

Q Okay. When you made rounds, did you make notations as to each and every resident who was under your care?

A Absolutely not.

Q Why is that?

A It would be incredibly time consuming, and it's not necessary for patient care.

Q So you had to budget your time among all the residents who were under your care at any of the given nursing homes?

A I completely disagree with the statement as you made it. The way it works is any patient on a skilled unit has to be seen once a month according to federal and state regulations, and an entry has to be made in the patient's chart once a month. Patients on intermediate care only have to have an

entry every two months. Those are the regulations, and the paperwork as it is in front of me meets those regulations, and that's why these are written this way, to meet those regulations.

That is not, however, a reflection of the actual time and energy I spend in the nursing home with an individual patient. The answer to that is I spend whatever time is necessary to take care of the patient. And that may mean phone calls to family members from here in the office that don't even get documented in the records. It may mean hallway consultations with other physicians at the hospital, as it did in this case.

Many things are not reflected in the records, so I very, very strongly disagree with the term "budget my time." The correct wording would be I spend whatever time is necessary to make sure the patients' needs are met. And, yes, we all budget our time in one way or another.

Q Sure. When you do visit a resident, is it your practice **to** make some chart notation?

A Part of the time, that is done, and there are other times when the resident is seen and no notation is made by me in the chart, but it may be made by nursing staff.

Q Is it proper practice every time the attending physician looks in on the resident for somebody to make a note of that?

A I'd say that happens most of the time, but not all of the time.

Q Mr. Mingus asked you some questions about some documents, which I actually saw for the first time today in the physician's notes for Beulah Willabor. What I'd like to do is mark them and ask you a couple questions about them.

MR. MINGUS: Note an objection to the previous question.

(Plaintiff'sExhibit 45 marked for identification.)

Q The two pages that I just marked as Exhibit 45, both of those are in your handwriting, correct?

A That's correct.

Q And those comprise all of the physician's notes for Beulah Willabor?

A I didn't personally copy the patient's chart, so I don't know the answer to the question.

Q All of the handwritten notes that you wrote for Beulah Willabor during the period of time that I'm asking about are on those two pages?

MR. MINGUS: Objection.

A I don't know because I didn't copy the patient's chart myself.
Q So there may be additional notes that you made in the chart that haven't been brought to your attention?
A Is that possible? Yes.
Q I don't know. I'm not the one who's providing you with documents.

MR. CRANDALL: I think that's his point. Neither does he.

A I didn't personally copy the chart, so I don't know the answer to the question.
Q Okay. I just noticed from the entries on those two forms that you seem to pretty much span the period of time that Mrs. Willabor was there. Would that be fair?
A Oh, yes.
Q So, normally, you would expect that there wouldn't be any notations in between the times that are noted there. They would be out of sequence or would be found somewhere else. That's a really bad question. If you can answer it, my hat is off to you.
A I'm lost in the labyrinth *of* the dependent clauses.
Q Let's strike it and try again.

Your physician's notes are kept in the

patient chart?
A That's correct.
Q Is it your practice when you are making rounds to check patient charts?
A As needed to take care of the patient.
Q Okay. Again, many patients' charts are voluminous. You don't check them all, so I assume you prioritize them?
A If you want to know how it works, I show up on the nursing unit, and I go through my folder. And I talk to the nurses, and I say, "What do you need taken care of today while I'm here?" And that could include a new patient such as when Mrs. Willabor came in on December 31st. It could include an established patient with some ongoing problem that needs to be addressed. The majority of the time, whatever I do does not get written down as a progress note like this. The majority does not get written down.
Q Okay. Mr. Mingus asked you a question about Beulah Willabor's care, and he asked you whether or not you were aware if she had lost weight during the time of her residency at Indian Hills.
A Okay.
Q Do you remember that question?

A Yes, I do.
Q I believe your answer was that you assumed that she did?
A Correct.
Q If she lost weight, would that be of concern to you?
A Of course.
Q Okay. How would you normally obtain that information?
A As I mentioned previously, at any given nursing home, there's a system in place whereby weight gain or weight loss of more than a specified amount within a specified amount of time sets off an alarm, and there's a protocol. that the nurses follow. Sometimes it's done by the nutritionist, whereby they alert the physician to the weight loss or weight gain.
Q So there's a certain level if you go above or beyond, a red flag goes up. Would that be correct?
A Correct.
Q Can you tell me what those parameters are?
A No. Because they are different for each nursing home, and they change over time, and they change for an individual patient over time.
Q Okay. Let me put it in these terms. A resident who's under your care, what kind of weight loss do

you want brought to your attention? Any weight loss? A pound? More than a pound?

A There isn't any one-size-fits-all number. If you're starting out with a 250-pound person and they lose 5 pounds, that's a vastly different issue than an 80-pound, debilitated, 96-year-old lady who loses 5 pounds. Vastly different implications even though the number is the same.

Q Let's talk about Beulah Willabor, and I could direct your attention to a document which I previously marked as Exhibit 13. Can you tell me what that document is?

A This is part of the nursing notes, and I'm not a nurse. I'm a medical doctor, and I'm not an expert and qualified to answer the question. But I will give you my best guess.

Q That's fine.

A This appears to be a form filled out by the nursing staff when the patient comes into the nursing home, documenting findings on physical exam, what we call the vital signs, meaning the height and weight and blood pressure and so on.

Q Okay. That's not a document that you typically refer to when you're caring for a resident?

A I won't say I never refer to this, but I can't

remember ever referring to it.

Q What's the date on that document?

A 12-31-96.

Q And does it indicate Mrs. Willabor's weight and height?

A The weight indicated is 110. The height is 5 foot 0.

Q Does it indicate any diagnoses?

A No words appear on this sheet of paper that I would call a diagnosis, no.

Q Is there a notation as to what Mrs. Willabor's ideal weight is?

MR. MINGUS: Objection. Go ahead.

A I don't see anything.

Q With the information that you have about this resident, do you have an opinion as to what her ideal weight would be?

MR. MINGUS: Objection.

A There's incomplete information to answer that question.

Q Let me put in front of you what I marked previously as Exhibit 16. This would be a nutritional supplement?

MR. CRANDALL: Nutritional assessment, you mean?

MR. CHAPMAN: Nutritional assessment.
A Yes, it's labeled a nutritional assessment.
Q Is that a document that you refer to when you're monitoring the status of your patient?
A No, it is not.
Q Do you make then, your own nutritional assessments for residents?
A My nutritional assessment of the residents is based upon what I'm told by the nursing staff.
Q In December of 1996, when Beulah Willabor became your patient, were you concerned about her weight?
A My history and physical on the patient lists the main diagnosis as failure to thrive. Failure to thrive includes malnutrition and concerns about weight.
Q Okay. So the short answer is, yes, you were?
A Yes.
Q You wanted to monitor the weight?
A It doesn't follow that one would monitor the weight unless you were going to pursue full measures upon the patient. Some patients get admitted to the nursing home merely for comfort measures, and you're not going to monitor that.
Q Was it your understanding that -- I want to make sure I understand your testimony here, Doctor. Was

Mrs. Willabor -- was maintaining Mrs. Willabor's weight a concern while she was under your care?

A The answer to the question is it depends on who you're talking about. If the expectation is that the patient is going to get better and we are going to do everything possible, the answer would be yes. If the expectation was the patient was being admitted for comfort measures or for what we call maintenance, the answer would be varying degrees of yes and no. So in other words, it depends what your goal is.

Q What was your goal for Beulah Willabor?

A The goal is whatever the family directs us to do.

Q What did the family direct you to do?

A As my notes state on March 6th of 1997, "comfort measures only."

Q Is maintaining nutritional status a part of a comfort measure?

A That's completely arbitrary. If you talk to ten different people, they'll give you ten different answers. So the answer *is* whatever the family decides. And, again, to quote from my own progress notes here, this time February 13th of 1997, "Discussed with family, no further aggressive interventions."

Q What aggressive interventions had you done up to that date?

MR. MINGUS: To what date?

MR. CHAPMAN: He read a note indicating no further aggressive interventions, so I'm asking what interventions had preceded that.

A All the medical nursing care which the patient had received up to that point, which is embodied in the physicians' orders and the nurses' progress notes and nursing notes.

Q So all the care she received at Indian Hills was aggressive and should be discontinued?

MR. MINGUS: Objection.

Q Is that your testimony?

A No, no, no.

Q I want to understand about Beulah Willabor. That's what I'm asking about right now.

A The answer to your question is no.

Q There's reference to "further aggressive actions." My question is whether or not there were any previous aggressive actions taken with respect to her care.

A The answer to the question is it depends on who's defining the word "aggressive."

Q I'm just asking you with respect to Mrs. Willabor.

She was your resident. You've got her chart in front of you, and I'm asking a question about her.

A The answer to the question is, it depends on who's defining the word "aggressive." My own personal definition may be different than, for example, Loretta Buxton's definition of the term.

Q Well, Doctor, it's your term used in the entry, so I want to understand what you meant when you made that entry.

A Okay. What I mean when I write that is it is an outcome of my conversation with the family and what they mean by it, so the answer is it means different things on different patients at different times when I made that entry. It doesn't mean the same thing, and I'm not saying that to give you a hard time.

Q Did you have an understanding of what the term "aggressive actions" meant when you wrote it down in your chart?

A Yes, I did.

Q What was that understanding?

A Feeding tubes.

Q No feeding tubes?

A Right. An aggressive measure would be a feeding tube. It also would be intubation. It also would be pounding on the chest in case the heart stops.

Q You responded to one of Mr. Mingus's questions by indicating that many families choose not to go with feeding tubes?
A That's correct.
Q Do you have an understanding as to why they may decide against them?
A Each case is individual, but more often than not, the decision gets made on the basis of patients' prior stated preferences and wishes, as in an advanced directive, for example.
Q What are the criteria, just from a purely medical standpoint, that would lead you to recommend that a feeding tube be used?
A If it's been called to my attention that the patient is not eating well and losing weight.
Q If a resident is capable of swallowing and is actually asking for hydration per mouth, is that resident a good candidate for a feeding tube?
A Each resident is different, and it depends on whether they are, first of all, willing to eat and, secondly, capable of eating. Under capable of eating, you have a very complex set of interventions and diagnostic maneuvers, which can include evaluation by a speech therapist, what we call a modified barium swallow, referral to an ear, nose,

and throat specialist to do indirect nasopharyngoscopy, evaluation by a gastroenterologist to evaluate the esophagus and stomach.

Q As you sit here today, do you know whether or not there was ever a determination made as to whether or not Mrs. Willabor was capable of eating?

A The way the question is asked can't be answered, but by way of clarifying, let me say that there isn't any difference between can't eat and won't eat on a practical basis.

Q Well, you were giving me a lengthy description of techniques that could be used to determine whether or not a resident is capable of eating, physically capable. My question is whether or not you know whether or not such an ascertainment was ever made as to Mrs. Willabor. Can you answer that question?

A Okay. When you say "such an ascertainment," you have to break it down into the individual things I listed.

Modified barium swallow was not done on this patient to the best of my knowledge. Referral to a gastroenterologist was not done to the best of my knowledge. Referral to an ear, nose, and throat specialist was not done to the best of my knowledge.

Whether a speech therapy evaluation was done is not known to me, but the information would be retrievable from the chart. And then you have your nursing assessment of how well the patient is eating, and that would also be embodied in the nursing notes. If the nutritionist is making some kind of notation about this, I assume that would be in the nutrition notes too.

Q Do I understand your testimony correctly that you don't know whether or not it was ever determined if Mrs. Willabor was capable of eating during the time she was at Indian Hills?

MR. MINGUS: Objection.

A What I know about it is what's contained in the areas that I just referred to. In other words, one would have to consult the nutritionist's notes, the nurses' notes, to answer the question. And do I have that information at my fingertips? No, I don't. Is it embodied in the patient's chart somewhere? Yes, it is.

Q I guess the answer would be that you don't know then? Would that be fair?

A That I don't know what?

Q That you don't know whether or not she was capable of eating during the time she was at Indian Hills.

MR. MINGUS: Objection.

A That I don't know whether she was capable of eating? The only answer I can give to that is on a practical basis, the difference between won't eat and can't eat amounts to the same thing, so all I need to hear from the nurses is the patient either won't eat or can't eat. And that sets in motion the discussion with the family about feeding tubes. So I think the answer to your question is that I don't differentiate between won't eat and can't eat, but I don't know if that answers your question.

Q Doctor, you responded to one of Mr. Mingus's questions regarding the development of ulcers, ulcerations, on Mrs. Willabor's body, by indicating that a feeding tube might have alleviated that problem or might have kept it from progressing as quickly as it did. Do you recall that testimony?

A Yes, I do.

Q Can you explain that?

A Okay. In a case such as this one, if a feeding tube had been placed, one would have expected the progression of her decubiti, which are bedsores, to have been slower, but nonetheless relentless.

Q Can you explain to me why the placement of a feeding tube would have slowed the development of decubiti?

A Malnutrition or poor nutrition or undernutrition is one of the contributing factors to the development of decubiti.

Q Regarding the failure to thrive diagnosis, is that a physical condition, failure to thrive, like tuberculosis or pneumonia, or what is that exactly?

A The term "failure to thrive" comes from the pediatric literature, and it refers to babies who don't feed well and who don't develop and grow well and just don't do well. They're runty r-u-n-t-y. They're runts.

You can see this again on the other end of life with frail, little old ladies that kind of are globally failing. They can't do things for themselves. They don't eat well. They are getting weaker, more prone to accidents. They do less of their ADLs, activities of daily living, just things that we all do to take care of ourselves. Intellectual decline, decreased problem-solving ability, decreased ability to respond to the environment, sensory deprivation and decline, meaning you don't see as well, you don't hear as well, you don't taste as well, you don't swallow as well.

Q Can the global failure that attends a failure to

thrive be related to nutrition?
A Yes.
Q What's that relationship?
A Cause and effect. Poor nutrition can cause failure to thrive, and failure to thrive can cause nutritional problems.
Q I would expect that in the case of an infant, that the failure to thrive designation would require that such an infant receive more care, rather than less, than a baby who's doing fine?
A Again, the answer depends completely on what your expectation and what your goal is. If your goal is to make the patient better and prolong life, life expectancy, then you would be more interventional. If the goal is comfort measures and not to prolong the life expectancy, then you would not necessarily do anything differently at all.
Q What does the phrase "comfort measures" mean?
A It means keep the patient comfortable and don't do anything more than that.
Q For somebody like Mrs. Willabor with multisymptoms that you've already testified about, what steps do you take to keep such a person comfortable?
A Again, the answer is in the nursing notes, all the things that nurses do to keep patients comfortable

in a nursing home.

Q So "comfort measures" is really a nursing term more than a doctor's term? Would that be accurate?

A It's really both.

Q What does it mean to you as a physician?

A It means different things on different patients at different times in different contexts.

Q What does it mean to you as to Mrs. Willabor?

A Again, it depends on what the family decided. And as I mentioned earlier, I have these conversations three or four times a day with different family members, so I can't directly remember on this particular case.

Q Okay. You have indicated that families make health-care decisions or certainly participate in health-care decisions?

A That's correct.

Q And in the context of comfort measures, you would turn to the family for guidance as to what measures to provide and what measures not to provide. Would that be accurate?

A That's correct.

Q What about selection of a nutritional supplement if there's a range of nutritional supplements available, is that a decision that's made by the

family?

A Okay. The selection of what nutritional supplement used on a given patient at a given time is determined by the recommendation of the nutritionist or whoever is involved in making the recommendation about the patient's nutrition, also the nurses who have to actually feed the patient, and sometimes the input from family members.

An example of that will be nutritionists will recommend a certain thing. The nurses will say, "She's not going to eat that. She will refuse to eat that. Try something else." And then a family member may chime in saying, "She loves watermelon, but she won't eat ice cream." They'll know food preferences, so it's a combination of all those inputs.

So needless to say, that's different for each patient at different contexts at different times, and it may change as the patient becomes more involuted. She may be able to safely eat something at one point in time, which later on she may not be able to safely take by mouth. So that too is dynamic. It changes over time.

Q Suffice it to say that it's important for the nursing staff and the physician to keep in touch

with the family about the resident's nutritional status?

A In some situations, it's very important, and other situations, it's not important whatsoever.

Q Explain that distinction.

A If you have a patient who, no matter what you do, is never going to get better, it becomes diminishingly unimportant. If you have a patient for whom you have an expectation that you are going to make them better or they are going to walk out of the nursing home and go back into the community, it's very important.

Q What about providing pain medications, is that a decision that's left up to the family? If the medical ascertainment or diagnosis is that this is a person who's suffering pain, do you have to yield to the family's directions as to whether or not to provide or withhold pain medications?

A Okay. The answer to the question about pain medications is you give the patients whatever they need regardless. If the family disagrees with your judgment, then you have to discuss it with them and sort it out and try to come to some kind of middle ground, but the patients get whatever they need. And I will add it's very unusual for the family to

disagree with whatever we decide to do to keep the patient comfortable.

Q Will I find in the chart notations as to the family's input and the family's decisions and the family's directives to Mrs. Willabor's health-care providers at Indian Hills?

A I don't know the answer to the question. I can only address the part that's handled by the physician.

Q What's the answer as to the physician?

A Well, the answer is that I talk to the family members on an as-needed basis if a decision needs to be made, as in this case where we talked about not introducing a feeding tube in February of 1997.

Q I'm looking for your physician notes. Can you read into the record the entry because I won't be able to read them.

A Yeah. I've got the one that we made this from.

Q Can you read the entry regarding feeding tubes?

MR. CRANDALL: He already read all these.

A I'm referring to my entry of February 13th, 1997, "no further aggressive interventions."

Q Do you specifically recall them saying "no feeding tubes"?

A No, of course, I don't. As I mentioned many times,

I have this conversation three or four times a day with various family members. In fact, since we've been sitting here, I've been paged four times, and I will bet one of these four pages has to do with this very issue about a patient in a nursing home at this time.

Q Mr. Mingus put in front of you something called an advanced directive --

A Yes.

Q -- which has been marked as Exhibit 7.

A Yes. I've got a copy of that right here.

Q Now, the top entry indicates that Mrs. Willabor does want fluids for hydration?

MR. CRANDALL: IV fluids.

Q IV fluids for hydration. Am I reading that correctly?

A Okay. The advanced directive is not signed by Mrs. Willabor. It's initialed by someone representing themselves as her legal guardian. And the signature is really poor, but I believe it's Mrs. Buxton's signature and her initials. And at the top of the advanced directive, there's an X with what I presume to be Mrs. Buxton's initial next to the entry that says, "I do want IV fluids for hydration."

Q Was it your understanding that the family had consented to provide Mrs. Willabor with IV fluids for hydration at the inception of her stay at Indian Hills?

A That's correct.

Q Okay. Did you determine at some point that she was dehydrated?

A Yes. The patient was dehydrated and malnourished.

Q Was there some reason that you didn't provide her with IV fluids for hydration?

A This would have gone back to the note of February 13, 1997, where I discussed with the family now, and had outcome of the discussion been that the family wanted IV fluids, then they would have been started at that time.

Q So it's your testimony then that IV fluids for hydration is an aggressive measure?

A Well, again, the term "aggressive measure" -- and I said several times now -- means completely different things in different contexts. In this context, my use of the term "aggressive intervention" in my progress note of February 13, 1997 includes IV fluids.

Q That's specifically noted in your notes marked as Exhibit 45?

A No, it's not.
Q How do you know?
A How do I know what?
Q How do you know that aggressive measures meant IV fluids?
A Okay. Because as I mentioned several times, I have this conversation several times a day with different family members, and because of the way that conversation is carried out routinely, the conversation goes something like this -- again, I'm paraphrasing -- your mother either can't eat or won't eat. She's becoming dehydrated and malnourished. Our choices are A, B, C, and D. And I need you to give me guidance as to where we should go with your mother at this time. And the outcome of that conversation is what gets recorded in the progress notes. And, very likely, the conversation took place at a time and place different than when this entry was made.
Q You don't have any specific recollection of that conversation, though?
A No. As I said several times --
MR. CRANDALL: Just answer.
Q And you don't have to say it again. You could just say no.

A That's correct. I do not have a recollection of whatever it is you just said.
Q But it's your understanding that when a family indicates on an advanced directive what course of treatment they want, that can change?
A It does change.
Q It's a matter of consulting with the family when changes in status appear?
A That's exactly right.
Q So if the family had wanted -- indicated on Exhibit 7 that they do not want placement of tubes for nutrition, that could have changed as well?
A It frequently does.
Q Thank you. Now, Doctor I want to go back to your --

MR. MINGIJS: I have a check here through 3:00.

THE WITNESS: Okay.

MR. CRANDALL: How much longer are you going to be?

MR. CHAPMAN: I'm going to be a while.

MR. CRANDALL We've got to stop at 3:30.

MR. CHAPMAN: Why?

MR. CRANDALL: Because I have to go.

MR. CHAPMAN: That's fine. We're

going to have to reconvene.

MR. CRANDALL: We can deal with that later.

MR. CHAPMAN: We've got a trial coming up on June 17th.

MR. CRANDALL: That's fine. There's no reason this depo should have taken this long.

MR. CHAPMAN: Pardon me?

MR. CRANDALL: I don't know what part you didn't understand.

MR. CHAPMAN: My client is a woman who died. I'm representing the family.

MR. CRANDALL: This isn't a wrongful death case against my client. This is a fact witness. He's already given up two hours and ten minutes of his time, and he's a professional. So if you want to apply to the court for more time, then go ahead.

MR. CHAPMAN: I certainly will because I have not been that long with this witness.

MR. CRANDALL: You have. He said, "I told you before," about 200 times, and you're asking the same questions over and over.

MR. CHAPMAN: I'll tell you what, I'll try and zip it along.

By Mr. Chapman:

Q Doctor, can we go to Exhibit 41, which is the order that you put on? Doctor, I'm referring you now to the physician's telephone order dated January 21st. There's reference to something called Lasix?

A Correct.

Q Is that something that you consulted with the family about before putting her on?

A No.

Q Why did you put her on that?

A I don't remember. I can give you my best educated guess.

Q I don't want you to guess. I want you to tell me what you know.

A Okay. I don't know.

Q Lasix, you identified as a diuretic?

A That's correct.

Q Are you familiar with the properties of Lasix?

A I couldn't practice medicine without being familiar with the properties of Lasix.

Q In a thumbnail, Doctor, what impact does Lasix have on a resident's body?

A Okay. It's a diuretic, which means that it removes extra fluid from the body.

Q Does the use of Lasix require careful medical

supervision?
A In some situations.
Q And require that dose and dose schedule be adjusted to the individual patient's needs?
A In some situations, it requires very, very, very, very close supervision, and other situations, it requires relatively less.
Q In Mrs. Willabor's case on January 21st of 1997, did it require close supervision?
A It required the level of supervision which the patient received at that time.
Q What level --
A The level of supervision would be my physical presence in the nursing home three times a week and ongoing nursing care.
Q Could you flip forward --
A I haven't finished. And a chest X-ray, which was ordered at that time, to ascertain whether the patient had fluid in her lungs.
Q Would you flip forward two pages? There's an entry of January 30th of 1997. Is that your entry in the top there, sir?
A I'm sorry. When you say my entry --
Q Your physician te1ephone order. Did you call that in?

A I don't remember.
Q It says, "Please weigh resident QOD." Does that have any meaning to you?
A Of course, it does.
Q What does it mean?
A It means weigh the patient every other day.
Q Do you recall -- is that unusually frequent, or is that customary, or do you recall the reasoning behind putting that order in?
A Do I recall the reasoning? No. But I can deduce it from looking at the chart.
Q What's your deduction?
A The patient is not eating well, and she's also on a very low dose of a diuretic, so her weight needs to be monitored fairly closely.
Q And the way the information regarding the weight comes to you is through the nurses?
A Correct. Now, I will say that occasionally if the nutritionist stops me at the nursing home and will share some nutritional concerns with me, I sometimes will directly deal with it through the nutritionist rather than the nursing staff.
Q But you expect through one vehicle or another for the weekly weights or the every-other-day weights to come to your attention in some form or another?

A Again, as we talked about before, there are certain alarm limits. If the weight goes up or down a certain amount within a certain period of time, a physician is to be notified.

Q For Mrs. Willabor in the end of January of 1997, in your mind, Doctor, when does the red flag go up? What kind of weight gain or weight loss?

MR. MINGUS: Objection.

A I really can't answer that question as asked. It isn't a specific number. It truly depends on the total clinical context of how the patient is doing and everything that is going on at that time.

Q If Mrs. Willabor lost 3 pounds in a month, is that something that you would want to be advised of?

MR. MINGUS: Objection.

A Same answer.

Q You don't know?

A No, it's not a don't know. What I'm saying is it completely depends on the clinical context, and if this case weren't a year and a half old, I might have a fresher memory for a particular case, but I just don't.

Q Are there any kinds of objective guidelines that are out there indicating when a resident's weight gain or loss is supposed to be flagged that you know of?

A If there are, it would be in the nutrition literature more likely rather than the medical literature, but not that I know of.
Q You're not aware of any?
A Not that I know of.
Q When you talk about the "total clinical picture," you have just recited a number of diagnoses that Mrs. Willabor had when she was admitted, but you're not comfortable opining as to what her complete clinical picture was given the parameters of her weight on admission and the diagnoses that she had?
MR. MINGUS: Objection.
A Her complete clinical picture is terrible.
Q Given that complete clinical picture, how closely do you want to watch her weight?
A The answer is it depends on what the expectations are of whoever is looking at outcomes. If the family directs that everything possible be done and wants a high level of intervention, then we will do that. If we're going for comfort measures, as my progress notes state, then you're going to go mainly for comfort measures and not do a lot of tests and monitoring.
Q Prior to today, have you seen a nutritional assessment that was done of Mrs. Willabor?

A I perused the entire chart that's in front of me so if, in fact, the chart contains the pages that you're referring to, the answer is yes.

Q It's marked as Plaintiff's Exhibit 16. It's in front of you. Would you go to the entry marked March 7th, 1991?

A Okay. It must be 3-7-97.

Q I beg your pardon. Yes, it is '97, of course.

A I think I have it, yes.

Q Okay. Do you see the notation of a recorded weight loss of 44 pounds since January 27th, 1997?

A Yes, I do.

Q Do you see the notation above that of February 10th? It indicates weekly weights have been ordered.

A Correct.

Q And below that, weekly weights not noted?

A I see that, yes.

Q Okay. Did it ever come to your attention that Mrs. Willabor was not being weighed in accordance with your orders?

A I don't know the answer to the question because I don't remember. But I will tell you in the overall context of a patient not eating, I don't need that information. I know she's going to lose weight, so I don't need to have somebody tell me that. Plus, I

can walk in the room and look at the patient and tell that too.

Q Okay. So it's your understanding that she lost 44 pounds in six weeks because she was not eating?

MR. MINGUS: Objection.

A The records clearly answer the question here. Resident has been refusing meals. Repeatedly resident refuses meals. This entry is made more than once. And that goes back to the issue of the difference between won't eat and can't eat.

Q When we're talking about a woman who lost 44 pounds in six weeks, Doctor, is it still appropriate to have a person of that kind, given Mrs. Willabor's total clinical picture, on a diuretic?

A The answer to the question is that sometimes it would be, and sometimes it would not be. In this particular situation, the patient had some edema of her lower extremities, and the concern here -- and this becomes somewhat technical -- is the patient already has decubiti on her feet or on her lower extremities and then has some swelling on top of it. It's going to even slow down the healing more, so you want to get rid of the fluid. This was done with short-term use of a diuretic and with some elastic stockings.

Q What do you mean by "short-term use of a diuretic"?
A Well, in looking at the notes here and --
Q I just want to know what you mean by the term.
A Well, the answer is the duration during which this patient was on the diuretic, which is -- it was discontinued on March 12th, and it was started on January 21st, so it was about a six-week period.
Q It would basically approximate the period in which the 44-pound weight drop occurred?
MR. MINGUS: Objection.
A The answer is that's correct, and it's to be expected. One of the reasons for giving the diuretic is to get rid *of* excess fluids from the body, so you expect a weight loss.
Q So is it your view that the 44-pound weight loss during the time that she was on Lasix was a good and healthy thing to occur to her?
MR. MINGUS: Objection.
A Okay. The answer to the question is that the weight loss was due to a combination of the diuretic and the patient not eating. The fact that the patient is not eating is obviously not good and healthy for the patient. Lasix was used to get rid of the extra fluid which was impeding the healing of lower extremity decubiti, which was done in an attempt to

make the patient better.

Q Do you have specific recollections of these things, Doctor?

A No.

Q So you're not speaking from personal recollection of Mrs. Willabor's case?

A That's correct.

Q Okay. If, in fact, there are no weekly weights noted during this six-week period, Doctor, although there was an order on indicating this resident was supposed to be weighed QOD, in your opinion, is that proper nursing care?

MR. MINGUS: Objection.

A I don't have an opinion about that because I'm not a nurse, and I'm not qualified.

Q I believe Mr. Mingus asked you a question about whether or not Mrs. Willabor was receiving proper care while she as at Indian Hills, and you opined to a reasonable degree of certainty that she was.

A I was referring to the topical treatment that the patient was receiving to the decubiti.

Q When you give an order to a nursing staff, do you expect it to be carried out?

A Of course.

Q Is it improper for a nurse to fail to carry out your

order?

MR. MINGUS: Objection.

A There is something that's called nursing judgment, and if the nurse feels that the order is improper and should not be followed, then she has to exercise her or his nursing judgment and clarify it. For example, if the patient happens to be allergic to a medicine and the doctor phones in an order and says, "Put the patient on that medicine," but at the time that the order was given, nobody knew that she was allergic, an example nursing judgment would be to call the doctor back and say, "Doctor, we don't want to use this medicine because the patient is allergic," and further clarify it. So that's called nursing judgment, so the answer to your question is that nursing judgment has to be exercised.

Q I'm interested in this specific instance. We're not talking about an allergy. You have a resident with a history of dehydration, and you're putting her on Lasix, which is a diuretic, and you order her to be weighed every other day. Now in your opinion, is it proper for a nurse to ignore that order?

MR. MINGUS: Objection.

Q Do you have an opinion?

MR. MINGUS: Objection.

A I don't have an opinion about that.
Q Okay. Would it be -- would you expect a nurse to tell you that your order was being ignored?
MR. MINGUS: Objection.
A Would I expect a nurse to tell me that an order is being ignored? Not as stated, no.
Q Mrs. Willabor is your patient, and you're concerned to find out about her condition, correct?
A I have an ongoing relationship with the patient that includes being apprised of her condition at any point in time,
Q And you asked to be apprised, and yet she's not weighed for a six-week period.
MR. MINGUS: Objection.
A The answer is it doesn't exactly work like that. What may have generated the order to weigh the patient every other day may be the nutritionist wanting to monitor the patient's weight rather than my concern about her hydration, for example. So you'd have to know what generated the order to begin with to weigh the patient every other day.
Q Doctor, do you expect that a weight loss of 44 pounds on a woman who's 120 pounds at the end of January would have any negative effects on her health?

A The answer is the patient weighed 110, not 120.
Q On admission?
A According to the record in front of me, it says 110, and the answer to the -- the further answer to the question is that -- would I expect it to have a negative effect? Yes, but, more precisely, that the conspiracy of medical problems that caused her to lose weight is what I'm concerned about.
Q Doctor, look on the nutritional assessment that's in front of you. If you go to the second page, do you see the entry for 9-97?
A The patient expired on 7-97, so there couldn't be an entry for 9-97.
Q I'm sorry. 1-9-97. It's just the back of the first page.
A Okay.
Q Do you see an entry to the effect that her weight increased?
A Yes.
Q By 7 pounds?
A Yes.
Q And she then attained 117 pounds?
A Yes.
Q And that was in her first month at Indian Hills?
A Yes.

Q And if you go down to the next entry, which is 1-23-97, do you see that her weight increased to 120 pounds?

A Yes.

Q Is a weight gain of that magnitude consistent with the failure to thrive?

MR. MINGUS: Objection.

A The weight gain in this particular situation is probably due to fluid retention, and this is complicated to explain, but it probably should go into the record. When someone doesn't eat well, their protein levels drop in the blood, specifically the serum albumin. That's what holds fluid in the intravascular space, which is inside the blood vessels, and keeps it from going out into the soft tissues.

When the albumin level goes down, you get more swelling, more fluids going out into the soft tissues. So this weight gain is almost certainly not nutritional. In fact, it's probably just the opposite. It's probably because her serum albumin level was going down. There's less protein in the blood vessels, more fluid going outside the blood vessels, retaining fluid. Weight goes up.

Q Do you see the entry for January 27th?

A Yes, I do.
Q Is there a notation in the labs there as to what's going on with her albumin levels?
A Yes. Her albumin level is low. It's 2.7.
Q The use of Lasix would tend to dehydrate, you indicated; is that correct?
MR. MINGUS: Objection.
A The use of Lasix always would carry the potential for dehydration, if not monitored. But if used correctly, should not lead to dehydration.
Q What are the ways that the use of Lasix -- how do you monitor a resident who's on Lasix?
A You do serial weights. You monitor blood tests. You look at the patient clinically.
Q As I look at the notes which I marked as Exhibit 45 -- they are your notes, sir,
MR. CRANDALL: Right here. (Indicating.)
Are you going to go back to those? Is that what you want to look at?
MR. CHAPMAN: It's Exhibit 45.
MR. CRANDALL: Well, he's got them in here. I just wanted to know, is that what you're going to do. So we should flip to them?
MR. CHAPMAN: Please.

Q Do you have those in front of you now, sir?
A If you're referring to that, the answer is yes. (Indicating.)
Q We're talking about the same thing. Do you see any reference to the fact that Mrs. Willabor is on Lasix in any of your notes?
A No, I do not.
Q Why did you take her off Lasix?
A Okay. The answer is that I don't remember, but I can give you an educated guess.

MR. CRANDALL: I don't want you to guess. If you don't know, just say, "I don't know." He's going to go on to his next question.

A I don't know.
Q Doctor, you indicated that if Mrs. Willabor had been equipped with a nutritional feeding tube, a nasogastric tube, that might have slowed the development of her decubiti?
A That's right.
Q Because you say that there's a relationship between nutrition and skin status?
A Healing.

MR. MINGUS: Objection. Asked and answered. Go ahead.

Q The 44-pound weight loss that we're talking about,

could that also have contributed to the development of her skin problems?

MR. MINGUS: Objection.

Q Do you know?

A The answer could -- the answer is yes.

MR. MINGUS: Objection. Move to strike.

Q You've indicated, Doctor, that you expect that there can be a number of consequences for somebody who lost 44 pounds over a six-week period. Can you summarize for me what kind of consequences you would expect to see in a woman of Mrs. Willabor's status during this time period in her life?

A Yes. I expect her to decline globally and die.

Q Because of a 44-pound weight loss in a six-week period?

A No.

MR. MINGUS: Objection. Objection.

A No, no, no.

Q That's my question, Doctor.

A No. Because of the conspiracy of medical problems producing the inability or unwillingness to eat and, therefore, the weight loss. Now, the label for that, again, is adult failure to thrive syndrome.

Q So the 44-pound weight loss in a six-week period is,

in your view, irrelevant to her decline?

MR. MINGUS: Objection.

A I don't agree with that statement at all.

Q In what ways was it relevant to her decline? That's what I want to understand.

A In what way was what relevant to her decline?

MR. CRANDALL: The 44-pound weight loss.

A In what way was the 44-pound weight loss relevant to her decline?

Q Yes. **Do** you know?

A Okay. I don't know how to quantitate it, if you're looking for a quantification like it accounted for 50 percent of her decline or 20 percent.

Q I only want to know if you have an understanding as you sit here if that weight loss in a six-week period of time contributed to Beulah Willabor's decline.

A Did the weight loss contribute to her decline? Part of what I mean when I say she declined is that she's losing weight, so it's part of the definition of the word "decline" in the way that I use the word "decline."

MR. MINGUS: John, it's 3:30. How much more? Do you want to reconvene if necessary?

MR. CHAPMAN: Well, we need to reconvene.

MR. MINGUS: Okay.

MR. CHAPMAN: And I'll certainly work with counsel to work that out, and that's it. It's your witness.

MR. CRANDALL: I'm not going to ask him any questions.

MR. CHAPMAN: Do you want to advise him about his signature?

MR. CRANDALL: We are not going to waive. We will read the portion up to this point.

MR. CHAPMAN: I will order.

(Deposition concluded at 3:31 p.m.)

(Signature not waived.)

- - -

I have read the foregoing transcript from page 1 through page 101 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____

Robert Whitehoues, M.D.

Subscribed and sworn to before me this_____day of _____, 1999.

_____

Notary Public

My commission expires_____

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

I, Luanne K Howe, Court Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, Robert Whitehouse, M , was 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 was by me reduced to steno type/computer in the presence of said witness, afterward transcribed, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

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 10th day of May, 1999.

Luanne K. Howe

Luanne K. Howe, Court Reporter and
Notary Public in and for the State of Ohio.
My commission expires October 2, 1999.

State of Ohio,)
) SS:
County of Cuyahoga.)

- - -

IN THE COURT OF COMMON PLEAS

- - -

Loretta Buxton, Adminstratrix of the Estate of Beulah Willabor,)
Plaintiff,)
vs.) Case No. 98-358-043
) Kathleen S. Craig, J.
Indian Hills Nursing Center, et al,)
Defendants.)

- - -

Deposition of Robert Whitehouse, M.D., a witness herein, called by the defendants for oral examination, pursuant to the Ohio Rules of Civil Procedure, taken before Luanne K. Howe, court Reporter and Notary Public in and for the State of Ohio, at the office of Robert Whitehouse, M.D., 36001 Euclid Avenue, Suite B-15, Willoughby, Ohio 44094, on Tuesday, April 27, 1999, commencing at 1:00 p.m.

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Q She also had X-rays which were consistent with old granulomatous disease; is that correct?
A That's correct.
Q What is that?
A She means she was exposed to TB at one time, and it's considered inactive at this point.
Q She also had coronary artery disease; is that correct?
A Right.
Q What is that?
A Hardening of the arteries, of those arteries that supply the heart muscle itself.
Q She also had atherosclerotic cardiovascular disease; is that correct?
A No. Cerebrovascular disease.
Q What is that, Doctor?
A That's hardening of the arteries in those arteries that supply the vein.
Q She also had glaucoma; is that correct?
A That diagnosis was listed on the information which came in with her into the nursing home, but I don't personally diagnose glaucoma.
Q Doctor, I see you have your chart open to a certain page. What page is that?
A It's called a "History and Physical Record."

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Q Could you tell me about your history that you took when you first saw the patient?
A Yeah. As I mentioned, the term that's used to describe her overall condition is called adult failure to thrive syndrome. When physicians talk to each other about this, we sometimes use the more frivolous term, quote, total body failure, unquote. This means that she had something wrong with every part of her body, and it was globally failing.
Q Do you have any opinions as to what her future prognosis was or what her life expectancy was?
MR. CHAPMAN: At what point?
MR. MINGUS: At the time of her admission.
A At the time of her admission, her prognosis was somewhere between terrible and terminal. Her life expectancy is diminishingly small.
Q What do you mean by "diminishingly small"?
A She could die any time.
Q What other -- strike that, please.
Did she have any mental or psychological problems at the time of her initial admission?
A She had severe dementia.
Q What is that, Doctor?
A Dementia means loss of intellectual faculties.

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Q Did she have any other psychological problems at that time?
A I don't think she was really tested as such for other psychiatric diagnoses like depression, anxiety.
Q I note from some of the records that she was disoriented to place, time, and situation at the time of her initial admission; is that correct, Doctor?
A You mean do I remember that, in fact, she was disoriented in that way? I don't remember, but do the records indicate that? Yes, they do.
Q Doctor, at the time of her initial admission to Indian Hills, there was an advanced directive that was signed; is that correct?
A Yes.
Q Okay. Doctor, let me hand it to you. It's been previously marked as Plaintiff's Exhibit 7. That's a copy of an advanced directive that was signed at the time of Mrs. Willabor's initial admission to Indian Hills; is that correct?
A Again, I wasn't personally there when they did this, but does this resemble the form that we use in these situations, and does it look like it's been formally signed correctly? Yes, it does.

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Q That's your signature on the bottom of the advanced directive?
A Yes.
Q What is an advanced directive?
A It's a directive on the part of the patient or their guardian stating what level of aggressiveness is to be undertaken should the patient's condition deteriorate.
Q And what did the advanced directive in Mrs. Willabor's case provide?
A The advanced directive states that we are not to pound on the patient's chest or intubate her, or place a tube through her nose into the stomach to feed her.
Q And that advanced directive is purportedly signed by Mrs. Willabor's daughter, Loretta Buxton; is that correct?
A Anybody's guess on this one. I wouldn't go out on a limb to say what that signature says there. (Indicating.)
Q When a patient's family signs an advanced directive which prohibits the use of a feeding tube, how does that affect the way that you can take care of a patient's nutritional status?
MR. CHAPMAN: Objection. Go ahead.

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congestive heart failure, arteriosclerotic heart disease, arteriosclerotic cerebrovascular disease, chronic atrial fibrillation, peripheral vascular disease, osteoporosis, degenerative arthritis, Paget's disease of the bone, anemia, hypertension, bronchitis, folate deficiency, left ventricle hypertrophy, glaucoma, old heart attack per EKG, right lung nodule, early decubiti, cholelithiasis, electrolyte imbalance, multiple nonspecific laboratory abnormalities. Other per attached, meaning records from the hospital.

Q What is early decubiti?

A Bedsores.

Q She had bedsores at the time of her initial admission?

A According to my notes.

Q That was located on the scapula?

A Both scapulae.

Q Where is the scapula located?

A Back here. (Indicating.)

Q You're pointing to the shoulder blade area?

A Superior-posterior thoracic area.

Q Your history also indicates a right lung nodule?

A Correct.

Q What was that, Doctor?

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A It was never ultimately diagnosed. The patient was seen by a specialist, who is Dr. Epstein, who saic if we were to evaluate it, the patient would need a CAT scan of the chest. And, again, after some discussion with Dr. Epstein and/or the family, we decided that we wouldn't do anything about whatever it was anyhow given her other multiple medical problems. So it was ultimately decided not to get the CAT scan of the chest.

Q What is folate deficiency?

A Folate is one of the B vitamins. It's in your diet. Almost all folic deficiency in the United States is due to malnutrition.

Q Did she have signs of malnutrition at the time of her initial admission?

A Yes.

Q Could you tell me about those, Doctor?

A Well, you're mostly talking about how the patient appears clinically, meaning that they look thin. They look malnourished. They look chronically ill. There are also some chemical indices that we use like serum albumin and some vitamin levels, calcium levels, and so on that are markers for nutrition.

Q Would you describe her as being cachectic at the time of her initial admission?

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A My notes don't show cachexia as such, so I'd have to see a photograph of the patient before I could answer that.

Q Doctor, was she taking any medication at the time of her initial admission?

A I'm sure she was, and that would be on the medication list, which I don't actually have here. I'm sorry. We do have it. It's about a page and a half of medications.

Q Could you tell me what she was taking and what she was taking it for?

A Yes. She was on a folate supplement, which is a vitamin supplement. She was on one baby aspirin a day to help thin the blood out. She was on an antidepressant called Zoloft. She was on a nitroglycerin patch, which we use for coronary artery disease. She was on a medicine called Digoxin, which we use to regulate the heart beat. She was on Lisinopril, which is a medication we use for more than one thing. Probably in her case, it was being used for the congestive heart failure and possibly for hypertension.

She was on an inhaler to help keep her breathing tubes open. She was on nutritional supplements three times a day and a medicine as

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needed for constipation. Also, at one point, she was on an antibiotic, and at one point, she was on a medicine called Lasix, which is a diuretic we use for heart failure.

Q Did you place her on Lasix during her stay?

A She was on Lasix when she came in, I believe. To be honest, I can't read about half of it. It's just a poor quality copy, but it would make sense that she probably was on Lasix when she came in, which is one of the medicines they use for treating heart failure.

Q Doctor, I'd like to refer you to your physician's orders. Do you have those in front of you?

A Yes. Okay, yeah. Here, I can clarify this for you. The date is cut off on this, but, actually, January 21st of '97, the patient was started on Lasix for some swelling of her lower extremities.

Q I note from your order of January 27th of 1997 that you started her on Rocephin; is that correct?

A Yes.

Q What is Rocephin?

A It's an antibiotic.

Q And on your order immediately before that dated January 28th, 1997, Mrs. Willabor was transferred to Room 404-A; is that correct?

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down into specifics because the statement is so broad.

Q Doctor, I'd like to take you back to your physician's notes, if you could take me through those, please. First of all, starting with your December 31st, 1996 note --

MR. CHAPMAN: Excuse me. I'm not sure I'm referring to the same thing you are. Is that marked as an exhibit?

MR. MINGUS: NO.

THE WITNESS: Do you want to see it?

MR. CHAPMAN: Can I get a quick copy?

THE WITNESS: How about if I do this. We've got a copy machine here, but in order to answer his question, I have to have this.

MR. CRANDALL: Do you want a copy of all of them? You don't have any of them?

MR. CHAPMAN: I have them somewhere. For some reason, they are not in my exhibit notebook.

THE WITNESS: Can I answer his question first?

MR. CHAPMAN: Yeah, why don't you do that, and we can go off the record for a minute.

A Coming back to your question now, on

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December 31st of 1996, my entry says, "Per the history and physical --" that means refer to the page that we previously discussed called the "History and Physical Records," and then in quotes it says, "partial measures," unquote. What that is is a clarification of what the patient's advanced directive is, and in this case, it's not, quote, full measures, which means do everything possible. And it's not, quote, an actual DNR, which means don't do any aggressive measures. It was kind of in the gray area in between as specified on the advanced directive, which we've already discussed as well in some detail, so that's what that entry refers to. Shall I keep going?

Q Well, why don't we stop, and you can get John a COPY.

MR. CHAPMAN: Thank you.

(Discussion off the record.)

Q Why don't you walk me through your January 18th, 1997 progress note?

A Sure. The progress note of January 18th of 1997 states that the patient didn't have any apparent complaints. She was confused, but pleasant. Her temperature was okay. Her vital signs were okay. She was not eating well.

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Lab work was reviewed and was found to be okay at that time. The chest X-ray showed the chronic granulomatous disease, which we already referred to, which in my opinion does not need treatment, as my note states, and that we were monitoring blood levels of some of the medicines.

Q Why did her chronic granulomatous disease not require treatment?

A The reason in this patient why you would not treat this is because it's old. It just refers to the patient having been exposed at one time to TB, and it's not active.

Q Could you go on to your February 13th note, please?

A Yes. This is the note we referred to previously. The patient continues to globally decline. I discussed with family. No further aggressive interventions. Multiple lab abnormalities now, which are consistent with dehydration and her poor intake, which is to be expected, of course.

Q What ways are there to treat dehydration?

A We've already discussed that before. It includes passing a tube down from the nose into the stomach, creating an opening in the abdominal wall and passing a tube through there and feeding through that tube, intravenous fluids, and then the

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previously mentioned TPN, total parenteral nutrition, involving the placing of a central line in the chest cavity.

Q And can you tell me why none of those particular measures were taken to treat her dehydration?

A Because I discussed it with the family, and they didn't want anything further done. I might add that intravenous fluids are not a permanent solution. You could use those for a few days, but you can' keep IVs in forever. They have to be changed every three days so that the lines don't become infected

Q What would be the permanent solution or the more long-term solution to treating dehydration? Would that be the feeding tube?

A The feeding tube, yes. And even the tube that goes from the nose into the stomach is not considered permanent. You can use that up to a month or two, but that causes complications too, so the only permanent one would be the tube that goes right through the abdominal wall into the stomach, which is called a PEG tube, P-E-G.

Q I take it then, Doctor, that you determined that using intravenous fluids would not have been a solution to Mrs. Willabor's dehydration problems?

A It would have been a short-term solution -- or shall

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medical certainty?
MR. CHAPMAN: Objection.
A Yes, it is.
Q Could you read your March 24th note, please, Doctor -- I'm sorry -- your April 24th note?
A At this point, the patient was evaluated in some way by Dr. Epstein, who as I mentioned previously is the lung specialist, and who at that point had said a CAT scan of the chest would have to be done to evaluate the nodule, so my note indicates CAT scan of chest pending, meaning further pulmonary follow-up.
Q Do you know if the CAT scan of the chest was ever taken?
A As my notes indicate -- again, I'm reading between the lines here, it was eventually decided not to do the CAT scan for the reason we talked about previously, which is that the patient was to be comfort measures only, so even if we did the CAT scan and it was abnormal, it would give us information that wouldn't change what we would do with the patient.
Q Doctor, could you read your next note, please?
A Yeah. In fact, that's what the next note says, "Do not feel CAT scan of the chest should be pursued

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further." And my memory of this is that I talked to Dr. Epstein during that time, and that was what we decided between the two of us. And I think we have a note from Dr. Epstein somewhere that probably indicates that. And at that point too, we're doing cultures on the wounds to see what kind of bugs grow out.
Q Did you refer Mrs. Willabor to Dr. Epstein?
A Yeah. Dr. Epstein's note is from May 6th of 1997. And at that point too, she had pneumonia.
Would it be appropriate for me to quote fron his notes?
Q Sure.
A Quote, "In view of general health and age, do not feel FOB is warranted." There's another word I can't read. "Evaluate with diagnostic workup as above." And I do recall talking to Dr. Epstein at this time since I see him almost every day, and I'm 99 percent sure that our mutual decision was that we shouldn't, as we say, "drag this lady through any more tests," unquote, is how we would have said it to each other because it wouldn't change our management.
Q Could you read your next note, please, Doctor?
A We are up to June now. "Ongoing RX," meaning

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treatment, "to various areas per nursing notes." This refers to the patient's multiple bedsores, ant at this point, I discussed with Dr. Niemczura, who's a vascular specialist, to see if anything could be done to improve the blood supply to these areas that aren't healing. And, in fact, Dr. Niemczura's note is dated nine days previous to that, so he had obviously seen her in the meantime.
And, again, would it be appropriate for me to quote from Dr. Niemczura's notes?
Q Sure.
A In essence, what the note says is the patient has no blood supply to any of these areas and they are not going to heal, and he's recommending amputation. And, again, it's very likely I talked to Dr. Niemczura personally at the time because that's my practice to do that.
MR. CHAPMAN: Objection.
A And we agreed that she was never going to get better.
Q What role did the lack of blood supply have in the development of Mrs. Willabor's sores?
MR. CHAPMAN: Objection.
A Major.
Q Could you explain, please?

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A Any part of the body that doesn't get a blood supply dies, including areas of skin, which is called a bedsore.
Q Mrs. Willabor had sores on her right foot and ankle; is that correct?
A I'd have to look -- I know she had multiple decubiti. In fact, I've got pictures here, and the pictures are labeled as right foot. Yes, right foot and ankle, but also the right scalp.
Q To a reasonable degree of medical certainty, is it your opinion that the lack of blood supply was a cause of sores on Mrs. Willabor's right foot and ankle?
MR. CHAPMAN: Objection.
A It was a major cause. And also the right buttocks is listed too, so the scalp, the buttocks, right foot, right ankle. She had multiple sites.
Q What was done to treat Mrs. Willabor's sores?
A She was receiving ongoing topical treatment of one sort or another and also antibiotics intermittently.
Q What do you mean by topical treatment?
A This is one where you have to consult the nursing notes to see what she was getting, and probably she was getting different treatments to different sites at different times. I can tell you the types of

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A I don't know how to answer the question because I don't know what the legal definition of "negligent" is. I assume -- that's not a medical word. It's a legal word, and I don't know what it means.
Q Okay. Do you have any opinions as to whether or not anything else could have been done to prevent -- let me rephrase that. Why do you believe Mrs. Willabor was more prone to fall than perhaps other people?
MR. CHAPMAN: Objection.
A Just what I just said. You know, just advanced age, frailty, total body failure.
MR. MINGUS: Doctor, I don't have anything else for you right now. Thank you very much for your time.
CROSS-EXAMINATION
By Mr. Chapman:
Q Doctor, my name is John Chapman. I'm the attorney along with Cal Hurd, the gentleman to my left, the attorney for the Beulah Willabor family. I have some questions for you as well.
A Sure.
Q Before coming to today's deposition, sir, did you review any papers?
A Wherever I got this pile of papers from was reviewed by me.

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Q Okay. And that comprises the complete chart?
A (Indicating.)
Q You're pointing out two additional documents to me. So there's a notebook in front of you, and you reviewed that prior to today. You also reviewed those photographs. And what's the other document?
A The document is not labeled. My guess is that this is copies of the nursing notes.
Q May I see it, please?
A (Witness complies.) Since it's about half legible, I'm not completely sure.
Q Doctor, during your testimony, you referred to notes from Dr. Niemczura?
A Niemczura.
Q Niemczura?
A Yes.
Q And also Dr. Epstein?
A Yes.
Q Could you point those out to me?
A I'm holding them in my hand right now.
Q May I see those two pages, please?
A (Witness complies.)
Q Thank you. Doctor, you're a medical doctor?
A Yes.
Q Where did you get your license?

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A University of Wisconsin.
Q When?
A I'm *sorry.* When you say "license," do you mean my medical degree?
Q Yes.
A Graduated in 1974.
Q Okay. Are you board certified in any area?
A I'm board certified in family practice, and I have a fellowship in geriatrics.
Q Would you basically describe for me your current practice?
A Solo family practice with an emphasis on geriatrics.
Q How long have you practiced in that fashion?
MR. CRANDALL: Go ahead and answer the question, then make copies.
A How long have I been in practice?
Q How long have you been a solo family practitioner with an emphasis in geriatrics?
A Intermittently since 1977.
Q Do you have staff privileges at any hospitals?
A Yes. Lake Hospital Systems East, Lake Hospital Systems West, Laurelwood, Mount Sinai East, Meridia Euclid, Hospice House, and teaching staff at Case Western.
Q Did you talk to anybody other than your attorney in

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preparation for today's deposition?
A No. You know what? I did get a phone call from -- can you excuse me for one second? Let me get another piece of paper.
(Witness was temporarily excused.)
A I actually got a letter from -- I said phone call. That was incorrect. A letter from Loretta Buxton that was dated March 22nd, and I did call her back to address the concerns in the letter. (Indicating.)
Q My question was whether or not you talked with anybody other than your attorney, who's here today, about --
A Yeah, I spoke with Loretta Buxton.
Q You spoke with Miss Buxton. What did you discuss with Miss Buxton?
A Boy, I would have addressed whatever she is asking about in her letter. And, basically, the letter says, would you talk to Mr. Chapman.
Q Is that what you discussed with her?
A Yes.
Q How did you respond to that question?
A I said that we had already set up an interview to talk to somebody, and then I received a phone call from somebody else saying, no, no, no, don't talk to

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A Yes. It's called the chart, and it's at the nursing home. And I'm holding a copy or what is alleged to be a complete copy of the patient's chart in my hands at this time. (Indicating.)
Q So did you make entries into the charts at Indian Hills during visits to Indian Hills?
A The answer is it's done differently on different patients at different times depending on what's happening. But in general, every patient would have a monthly progress note. If there's something else going on above and beyond the average monthly visit, then additional notes are made.

And by the way, the documentation of conversations with physician and family members also occurs in the nursing notes and sometimes in the social service notes and other places too, so I'm referring now strictly to the physician progress notes.
Q If Mrs. Willabor or a member of her family wanted to contact you regarding the care that Mrs. Willabor was receiving at Indian Hills, what would be the normal mechanism for them to get in touch with you?
A Call the office. Now, sometimes family members will leave messages actually at the nursing home. There's a folder for each physician on each one of

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the nursing units. And I go to the nursing home three times a week, and I check each folder on each nursing unit. And I make sure it's clean by the time I leave. Occasionally, you'll have a message in the folder saying the family of so and so wants to talk to you about their mother or whatever.
Q Is it your practice to wear a white coat when you're making the rounds at Indian Hills?
A I never wear a white coat. It's scares the patients.
Q Now, from time to time, do you call -- I think you indicated that you called upon physicians in other specialties --
A That's correct.
Q -- to assist you when a particular problem came up?
A That's correct.
Q And you referenced already Dr. Epstein and Dr. --
A Niemczura.
Q -- Niemczura. Are Dr. Epstein and Dr. Niemczura also on staff at Indian Hills?
A Not that I know of. It's very unusual to have a specialist come into nursing homes. It happens occasionally.
Q Why is that?
A They just don't do it.

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Q You can't get them to come in?
A That's correct.
Q Why are they reluctant to come in?
A You'd have to ask them that.
Q What is this specialty that you have in -- it's family medicine and geriatrics. Are you essentially an internist?
A No. There are two separate things. One is -- I did a three-year residency in family practice, and I'm board certified in family practice. Our organization is the American Academy of Family Physicians, so I'm a fellow of the AAFP. I'm board certified in family practice.

As a separate specialty, I have a fellowship in geriatrics, and I'm, therefore, also a fellow of the American Geriatric Society. *So* that makes me a FAGS, F-A-G-S, and a FAAFP, F-A-A-F-P. They are separate fellowships, though.
Q Okay. Is a specialty in geriatrics -- exactly what is it that you're able to do? Is it diagnosing infirmities of the aged, or can you treat a wide variety of infirmities of the aged?
A That's correct.
Q Do you have staff privileges at any nursing homes other than Indian Hills?

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A 25. It's actually more.
Q How many patients do you have who are residents in nursing homes at any given time?
A I think it's in the hundreds. I don't know the exact number. My billing lady could give you an up-to-date, exact number.
Q So you visit 25 nursing homes three times a week?
A No. The nursing homes that I visit three times a week are just my real busy, larger nursing homes because there's so much work to do. I have to go in three times a week to get all the work done. But other nursing homes, I may only have one or two patients. I go in once a month and just as needed if they get sick or something.
Q Doctor, I served a subpoena on you at the end of last week requesting that you produce certain documents that I could refer to during the deposition. One of them was any documents that evidence, relate, or pertain in any way to the manner in which Beulah Willabor's medical care was assigned or referred to you. Do you remember that request?
A As you're reading it now, yes.
Q Okay. Do you possess any such documents?
A The only documents I know of relevant to this

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Beulah Willabor was a resident at Indian Hills, and we established that that was sometime towards the very end of December 1996, and we have also established that she died in July of 1997. So do you have that period of time in mind?

A I sure do.

Q Okay. Is it your testimony that you made rounds at Indian Hills about three times a week?

A Yes, absolutely.

Q Okay. When you made rounds, did you make notations as to each and every resident who was under your care?

A Absolutely not.

Q Why is that?

A It would be incredibly time consuming, and it's not necessary for patient care.

Q So you had to budget your time among all the residents who were under your care at any of the given nursing homes?

A I completely disagree with the statement as you made it. The way it works is any patient on a skilled unit has to be seen once a month according to federal and state regulations, and an entry has to be made in the patient's chart once a month. Patients on intermediate care only have to have an

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entry every two months. Those are the regulations, and the paperwork as it is in front of me meets those regulations, and that's why these are written this way, to meet those regulations.

That is not, however, a reflection of the actual time and energy I spend in the nursing home with an individual patient. The answer to that is I spend whatever time is necessary to take care of the patient. And that may mean phone calls to family members from here in the office that don't even get documented in the records. It may mean hallway consultations with other physicians at the hospital, as it did in this case.

Many things are not reflected in the records, so I very, very strongly disagree with the term "budgetmy time." The correct wording would be I spend whatever time is necessary to make sure the patients' needs are met. And, yes, we all budget our time in one way or another.

Q Sure. When you do visit a resident, is it your practice to make some chart notation?

A Part of the time, that is done, and there are other times when the resident is seen and no notation is made by me in the chart, but it may be made by nursing staff.

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Q Is it proper practice every time the attending physician looks in on the resident for somebody to make a note of that?

A I'd say that happens most of the time, but not all of the time.

Q Mr. Mingus asked you some questions about some documents, which I actually saw for the first time today in the physician's notes for Beulah Willabor. What I'd like to do is mark them and ask you a couple questions about them.

MR. MINGUS: Note an objection to the previous question.

(Plaintiff's *Exhibit* 45 marked for identification.)

Q The two pages that I just marked as Exhibit 45, both of those are in your handwriting, correct?

A That's correct.

Q And those comprise all of the physician's notes for Beulah Willabor?

A I didn't personally copy the patient's chart, so don't know the answer to the question.

Q All of the handwritten notes that you wrote for Beulah Willabor during the period of time that I'm asking about are on those two pages?

MR. MINGUS: Objection.

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A I don't know because I didn't copy the patient's chart myself.

Q So there may be additional notes that you made in the chart that haven't been brought to your attention?

A Is that possible? Yes.

Q I don't know. I'm not the one who's providing you with documents.

MR. CRANDALL: I think that's his point. Neither does he.

A I didn't personally copy the chart, so I don't know the answer to the question.

Q Okay. I just noticed from the entries on those two forms that you seem to pretty much span the period of time that Mrs. Willabor was there. Would that be fair?

A Oh, yes.

Q *So,* normally, you would expect that there wouldn't be any notations in between the times that are noted there. They would be out of sequence or would be found somewhere else. That's a really bad question. If you can answer it, my hat is off to you.

A I'm lost in the labyrinth of the dependent clauses.

Q Let's strike it and try again.

Your physician's notes are kept in the

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MR. CHAPMAN: Nutritional assessment.
A Yes, it's labeled a nutritional assessment.
Q Is that a document that you refer to when you're monitoring the status of your patient?
A No, it is not.
Q Do you make then, your own nutritional assessments for residents?
A My nutritional assessment of the residents is based upon what I'm told by the nursing staff.
Q In December of 1996, when Beulah Willabor became your patient, were you concerned about her weight?
A My history and physical on the patient lists the main diagnosis as failure to thrive. Failure to thrive includes malnutrition and concerns about weight.
Q Okay. So the short answer is, yes, you were?
A Yes.
Q You wanted to monitor the weight?
A It doesn't follow that one would monitor the weight unless you were going to pursue full measures upon the patient. Some patients get admitted to the nursing home merely for comfort measures, and you're not going to monitor that.
Q Was it your understanding that -- I want to make sure I understand your testimony here, Doctor. Was

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Mrs. Willabor -- was maintaining Mrs. Willabor's weight a concern while she was under your care?
A The answer to the question is it depends on who you're talking about. If the expectation is that the patient is going to get better and we are going to do everything possible, the answer would be yes. If the expectation was the patient was being admitted for comfort measures or for what we call maintenance, the answer would be varying degrees of yes and no. So in other words, it depends what your goal is.
Q What was your goal for Beulah Willabor?
A The goal is whatever the family directs us to do.
Q What did the family direct you to do?
A As my notes state on March 6th of 1997, "comfort measures only."
Q Is maintaining nutritional status a part of a comfort measure?
A That's completely arbitrary. If you talk to ten different people, they'll give you ten different answers. So the answer is whatever the family decides. And, again, to quote from my own progress notes here, this time February 13th of 1997, "Discussed with family, no further aggressive interventions."

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Q What aggressive interventions had you done up to that date?
MR. MINGUS: To what date?
MR. CHAPMAN: He read a note indicating no further aggressive interventions, so I'm asking what interventions had preceded that.
A All the medical nursing care which the patient had received up to that point, which is embodied in the physicians' orders and the nurses' progress notes and nursing notes.
Q So all the care she received at Indian Hills was aggressive and should be discontinued?
MR. MINGUS: Objection.
Q Is that your testimony?
A No, no, no.
Q I want to understand about Beulah Willabor. That's what I'm asking about right now.
A The answer to your question is no.
Q There's reference to "further aggressive actions." My question is whether or not there were any previous aggressive actions taken with respect to her care.
A The answer to the question is it depends on who's defining the word "aggressive."
Q I'm just asking you with respect to Mrs. Willabor.

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She was your resident. You've got her chart in front of you, and I'm asking a question about her.
A The answer to the question is, it depends on who's defining the word "aggressive." My own personal definition may be different than, for example, Loretta Buxton's definition of the term.
Q Well, Doctor, it's your term used in the entry, so I want to understand what you meant when you made that entry.
A Okay. What I mean when I write that is it is an outcome of my conversation with the family and what they mean by it, so the answer is it means different things on different patients at different times when I made that entry. It doesn't mean the same thing, and I'm not saying that to give you a hard time.
Q Did you have an understanding of what the term "aggressive actions" meant when you wrote it down in your chart?
A Yes, I did.
Q What was that understanding?
A Feeding tubes.
Q No feeding tubes?
A Right. An aggressive measure would be a feeding tube. It also would be intubation. It also would be pounding on the chest in case the heart stops.

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A Malnutrition or poor nutrition or undernutrition is one of the contributing factors to the development of decubiti.
Q Regarding the failure to thrive diagnosis, is that a physical condition, failure to thrive, like tuberculosis or pneumonia, or what is that exactly?
A The term "failure to thrive" comes from the pediatric literature, and it refers to babies who don't feed well and who don't develop and grow well and just don't do well. They're runty r-u-n-t-y. They're runts.
You can see this again on the other end of life with frail, little old ladies that kind of are globally failing. They can't do things for themselves. They don't eat well. They are getting weaker, more prone to accidents. They do less of their ADLs, activities of daily living, just things that we all do to take care of ourselves. Intellectual decline, decreased problem-solving ability, decreased ability to respond to the environment, sensory deprivation and decline, meaning you don't see as well, you don't hear as well, you don't taste as well, you don't swallow as well.
Q Can the global failure that attends a failure to

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thrive be related to nutrition?
A Yes.
Q What's that relationship?
A Cause and effect. Poor nutrition can cause failur to thrive, and failure to thrive can cause nutritional problems.
Q I would expect that in the case of an infant, that the failure to thrive designation would require that such an infant receive more care, rather than less than a baby who's doing fine?
A Again, the answer depends completely on what your expectation and what your goal is. If your goal i to make the patient better and prolong life, life expectancy, then you would be more interventional. If the goal is comfort measures and not to prolong the life expectancy, then you would not necessarily do anything differently at all.
Q What does the phrase "comfort measures" mean?
A It means keep the patient comfortable and don't do anything more than that.
Q For somebody like Mrs. Willabor with multisymptom that you've already testified about, what steps do you take to keep such a person comfortable?
A Again, the answer is in the nursing notes, all the things that nurses do to keep patients comfortable

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in a nursing home.
Q *So* "comfort measures" is really a nursing term more than a doctor's term? Would that be accurate?
A It's really both.
Q What does it mean to you as a physician?
A It means different things on different patients at different times in different contexts.
Q What does it mean to you as to Mrs. Willabor?
A Again, it depends on what the family decided. And as I mentioned earlier, I have these conversations three or four times a day with different family members, so I can't directly remember on this particular case.
Q Okay. You have indicated that families make health-care decisions or certainly participate in health-care decisions?
A That's correct.
Q And in the context of comfort measures, you would turn to the family for guidance as to what measures to provide and what measures not to provide. Would that be accurate?
A That's correct.
Q What about selection of a nutritional supplement if there's a range of nutritional supplements available, is that a decision that's made by the

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family?
A Okay. The selection of what nutritional supplement used on a given patient at a given time is determined by the recommendation of the nutritionist or whoever is involved in making the recommendation about the patient's nutrition, also the nurses who have to actually feed the patient, and sometimes the input from family members.
An example of that will be nutritionists will recommend a certain thing. The nurses will say, "She's not going to eat that. She will refuse to eat that. Try something else." And then a family member may chime in saying, "She loves watermelon, but she won't eat ice cream." They'll know food preferences, so it's a combination of all those inputs.
So needless to say, that's different for each patient at different contexts at different times, and it may change as the patient becomes more involuted. She may be able to safely eat something at one point in time, which later on she may not be able to safely take by mouth. So that too is dynamic. It changes over time.
Q Suffice it to say that it's important for the nursing staff and the physician to keep in touch

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A No, it's not.
Q How do you know?
A How do I know what?
Q How do you know that aggressive measures meant IV fluids?
A Okay. Because as I mentioned several times, I have this conversation several times a day with different family members, and because of the way that conversation is carried out routinely, the conversation goes something like this -- again, I'm paraphrasing -- your mother either can't eat or won't eat. She's becoming dehydrated and malnourished. Our choices are A, B, C, and D. And I need you to give me guidance as to where we should go with your mother at this time. And the outcome of that conversation is what gets recorded in the progress notes. And, very likely, the conversation took place at a time and place different than when this entry was made.
Q You don't have any specific recollection of that conversation, though?
A No. As I said several times --
MR. CRANDALL: Just answer.
Q And you don't have to say it again. You could just say no.

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A That's correct. I do not have a recollection of whatever it is you just said.
Q But it's your understanding that when a family indicates on an advanced directive what course of treatment they want, that can change?
A It does change.
Q It's a matter of consulting with the family when changes in status appear?
A That's exactly right.
Q So if the family had wanted -- indicated on Exhibit 7 that they do not want placement of tubes for nutrition, that could have changed as well?
A It frequently does.
Q Thank you. Now, Doctor I want to go back to your --
MR. MINGUS: I have a check here through 3:00.
THE WITNESS: Okay.
MR. CRANDALL: How much longer are you going to be?
MR. CHAPMAN: I'm going to be a while.
MR. CRANDALL: We've got to stop at 3:30.
MR. CHAPMAN: Why?
MR. CRANDALL: Because I have to go,
MR. CHAPMAN: That's fine. We're

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going to have to reconvene.
MR. CRANDALL: We can deal with that later,
MR. CHAPMAN: We've got a trial coming up on June 17th.
MR. CRANDALL: That's fine. There's no reason this depo should have taken this long.
MR. CHAPMAN: Pardon me?
MR. CRANDALL: I don't know what part you didn't understand.
MR. CHAPMAN: My client is a woman who died. I'm representing the family.
MR. CRANDALL: This isn't a wrongful death case against my client. This is a fact witness. He's already given up two hours and ten minutes of his time, and he's a professional. So if you want to apply to the court for more time, then go ahead.
MR. CHAPMAN: I certainly will because I have not been that long with this witness.
MR. CRANDALL: You have. He said, "I told you before," about 200 times, and you're asking the same questions over and over.
MR. CHAPMAN: I'll tell you what, I'll try and zip it along.

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By Mr. Chapman:
Q Doctor, can we go to Exhibit 41, which is the order that you put on? Doctor, I'm referring you now to the physician's telephone order dated January 21st. There's reference to something called Lasix?
A Correct.
Q Is that something that you consulted with the family about before putting her on?
A No.
Q Why did you put her on that?
A I don't remember. I can give you my best educated guess.
Q I don't want you to guess. I want you to tell me what you know.
A Okay. Idon't know.
Q Lasix, you identified as a diuretic?
A That's correct.
Q Are you familiar with the properties of Lasix?
A I couldn't practice medicine without being familiar with the properties of Lasix.
Q In a thumbnail, Doctor, what impact does Lasix have on a resident's body?
A Okay. It's a diuretic, which means that it removes extra fluid from the body.
Q Does the use of Lasix require careful medical

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A I perused the entire chart that's in front of me so if, in fact, the chart contains the pages that you're referring to, the answer is yes.
Q It's marked as Plaintiff's Exhibit 16. It's in front of you. Would you go to the entry marked March 7th, 1991?
A Okay. It must be 3-7-97.
Q I beg your pardon. Yes, it is '97, of course.
A I think I have it, yes.
Q Okay. Do you see the notation of a recorded weight loss of 44 pounds since January 27th, 1997?
A Yes, I do.
Q Do you see the notation above that of February 10th? It indicates weekly weights have been ordered.
A Correct.
Q And below that, weekly weights not noted?
A I see that, yes.
Q Okay, Did it ever come to your attention that Mrs. Willabor was not being weighed in accordance with your orders?
A I don't know the answer to the question because I don't remember. But I will tell you in the overall context of a patient not eating, I don't need that information. I know she's going to lose weight, so I don't need to have somebody tell me that. Plus, I

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can walk in the room and look at the patient and tell that too.
Q Okay. So it's your understanding that she lost 44 pounds in six weeks because she was not eating?
MR. MINGUS: Objection.
A The records clearly answer the question here. Resident has been refusing meals. Repeatedly resident refuses meals. This entry is made more than once. And that goes back to the issue of the difference between won't eat and can't eat.
Q When we're talking about a woman who lost 44 pounds in six weeks, Doctor, is it still appropriate to have a person of that kind, given Mrs. Willabor's total clinical picture, on a diuretic?
A The answer to the question is that sometimes it would be, and sometimes it would not be. In this particular situation, the patient had some edema of her lower extremities, and the concern here -- and this becomes somewhat technical -- is the patient already has decubiti on her feet or on her lower extremities and then has some swelling on top of it. It's going to even slow down the healing more, so you want to get rid of the fluid. This was done with short-term use of a diuretic and with some elastic stockings.

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Q What do you mean by "short-termuse of a diuretic"?
A Well, in looking at the notes here and --
Q I just want to know what you mean by the term.
A Well, the answer is the duration during which this patient was on the diuretic, which is -- it was discontinued on March 12th, and it was started on January 21st, so it was about a six-week period,
Q It would basically approximate the period in which the 44-pound weight drop occurred?
MR. MINGUS: Objection.
A The answer is that's correct, and it's to be expected. One of the reasons for giving the diuretic is to get rid of excess fluids from the body, so you expect a weight loss.
Q So is it your view that the 44-pound weight loss during the time that she was on Lasix was a good and healthy thing to occur to her?
MR. MINGUS: Objection.
A Okay. The answer to the question is that the weight loss was due to a combination of the diuretic and the patient not eating. The fact that the patient is not eating is obviously not good and healthy for the patient. Lasix was used to get rid of the extra fluid which was impeding the healing of lower extremity decubiti, which was done in an attempt to

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make the patient better.
Q Do you have specific recollections of these things, Doctor?
A No.
Q So you're not speaking from personal recollection of Mrs. Willabor's case?
A That's correct.
Q Okay. If, in fact, there are no weekly weights noted during this six-week period, Doctor, although there was an order on indicating this resident was supposed to be weighed QOD, in your opinion, is that proper nursing care?
MR. MWGUS: Objection.
A I don't have an opinion about that because I'm not a nurse, and I'm not qualified.
Q I believe Mr. Mingus asked you a question about whether or not Mrs. Willabor was receiving proper care while she as at Indian Hills, and you opined to a reasonable degree of certainty that she was.
A I was referring to the topical treatment that the patient was receiving to the decubiti.
Q When you give an order to a nursing staff, do you expect it to be carried out?
A Of course.
Q Is it improper for a nurse to fail to carry out your

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A Yes, I do.
Q Is there a notation in the labs there as to what's going on with her albumin levels?
A Yes. Her albumin level is low. It's 2.7.
Q The use of Lasix would tend to dehydrate, you indicated; is that correct?
MR. MINGUS: Objection.
A The use of Lasix always would carry the potentia for dehydration, if not monitored. But if used correctly, should not lead to dehydration.
Q What are the ways that the use of Lasix -- how d you monitor a resident who's on Lasix?
A You do serial weights. You monitor blood tests. You look at the patient clinically.
Q As I look at the notes which I marked as Exhibit 45 -- they are your notes, sir.
MR. CRANDALL: Right here. (Indicating.)
Are you going to go back to those? Is that what you want to look at?
MR. CHAPMAN: It's Exhibit 45.
MR. CRANDALL: Well, he's got them in here. I just wanted to know, is that what you're going to do. So we should flip to them?
MR. CHAPMAN: Please.

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Q Do you have those in front of you now, sir?
A If you're referring to that, the answer is yes. (Indicating.)
Q We're talking about the same thing. Do you see any reference to the fact that Mrs. Willabor is on Lasix in any of your notes?
A No, I do not.
Q Why did you take her off Lasix?
A Okay. The answer is that I don't remember, but I can give you an educated guess.
MR. CRANDALL: Idon't want you to guess. If you don't know, just say, "Idon't know." He's going to go on to his next question.
A I don't know.
Q Doctor, you indicated that if Mrs. Willabor had been equipped with a nutritional feeding tube, a nasogastric tube, that might have slowed the development of her decubiti?
A That's right.
Q Because you say that there's a relationship between nutrition and skin status?
A Healing.
MR. MINGUS: Objection. Asked and answered. Go ahead.
Q The 44-pound weight loss that we're talking about, could that also have contributed to the development of her skin problems?
MR. MINGUS: Objection.
Q Do you know?
A The answer could -- the answer is yes.
MR. MINGUS: Objection. Move to strike.
Q You've indicated, Doctor, that you expect that there can be a number of consequences for somebody who lost 44 pounds over a six-week period. Can you summarize for me what kind of consequences you would expect to see in a woman of Mrs. Willabor's status during this time period in her life?
A Yes. I expect her to decline globally and die.
Q Because of a 44-pound weight loss in a six-week period?
A No.
MR. MINGUS: Objection. Objection.
A No, no, no.
Q That's my question, Doctor.
A No. Because of the conspiracy of medical problems producing the inability or unwillingness to eat and, therefore, the weight loss. Now, the label for that, again, is adult failure to thrive syndrome.
Q So the 44-pound weight loss in a six-week period is,

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in your view, irrelevant to her decline?
MR. MINGUS: Objection.
A I don't agree with that statement at all.
Q In what ways was it relevant to her decline? That's what I want to understand.
A In what way was what relevant to her decline?
MR. CRANDALL: The 44-pound weight loss.
A In what way was the 44-pound weight loss relevant to her decline?
Q Yes. Do you know?
A Okay. I don't know how to quantitate it, if you're looking for a quantification like it accounted for 50 percent of her decline or 20 percent.
Q I only want to know if you have an understanding as you sit here if that weight loss in a six-week period of time contributed to Beulah Willabor's decline.
A Did the weight loss contribute to her decline? Part of what I mean when I say she declined is that she's losing weight, so it's part of the definition of the word "decline" in the way that I use the word "decline."
MR. MINGUS: John, it's 3:30. How much more? Do you want to reconvene if necessary?