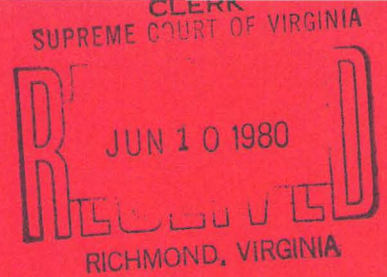


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IN THE

Supreme Court of Virginia

AT RICHMOND

RECORD NO. 791612

TEH LEN CHU

Appellant

v.

FAIRFAX EMERGENCY MEDICAL
ASSOCIATES, LTD.

Appellee

APPELLEE'S APPENDIX

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1 And if we do that as I believe our evidence will show you
2 without contra-indication or question on what I say. You will
3 have heard it yourself and have an opportunity to read the
4 evidence, most assuredly you will find on behalf of the
5 emergency room group, and I will ask for your unanimous
6 verdict.

7 Thank you very much.

8 * * * * *

9 Whereupon,

10 JAMES BEYER, M.D.

11 was called as a witness by and on behalf of the plaintiff,
12 and, having been previously duly sworn, was examined and
13 testified as follows:

14 DIRECT EXAMINATION

15 BY MR. HIRSCHKOP:

16 Q State your name, please.

17 A Dr. James V. Beyer.

18 Q Dr. Beyer, what is your profession?

19 A Deputy Chief Medical Examiner in charge of the
20 Northern Virginia Division Office of the Chief Medical
21 Examiner.

22 Q What is your medical specialty?

23 A Forensic pathology.

1 Q Would you state for the record -- unless the other
2 side will assert -- state he is an expert witness.

3 I guess not.

4 Will you state for record your background.

5 A Medical degree from Loyola University, Chicago.
6 Master of Science from the same institution.

7 Q What training, medical training did you have after
8 medical school?

9 A Fourteen years in the regular Army Medical Corps.
10 From 1963 to 1971 designated pathologist for the Medical
11 Examiner's Office for Northern Virginia. Since 1971 I have
12 been in charge of that office, board certified in anatomy and
13 forensic science.

14 Q How many autopsies would you say you have performed
15 in the medical examiner's office?

16 A Per Year?

17 Q Since you've been there all told.

18 A I can only give you an average per year which is
19 somewhere between nine hundred fifty and a thousand per year.

20 Q In other words, you've done thousands of autopsies?

21 A That is correct.

22 Q Your Honor, I tender him as an expert pathologist.

23 THE COURT: Any objection?

1 MR. SLENKER: No.

2 THE COURT: We receive Dr. Beyer's testimony as
3 an expert pathologist.

4 BY MR. HIRSCHKOP:

5 Q Dr. Beyer, did you perform an autopsy on Wing C.
6 Chu in about January, 1977?

7 A Yes, sir. This examination was conducted January 11,
8 1977, at 2:00 p.m. in my morgue at Fairfax Hospital.

9 Q Would you state to the jury what the examination
10 consisted of.

11 A External examination of the body for any signs of
12 trauma, scars or any other identifying marks. Internal
13 examination of all the internam organs for signs of trauma
14 or disease state. Microscopic examination of representative
15 samples from all the body viscera and collection of body
16 fluids and tissues for toxicology examination.

17 Q Did you examine the patient's stomach, the contents
18 of his stomach?

19 A Yes.

20 Q What did you find in his stomach?

21 A There was no evidence of any food material, but
22 there was material consistent with residual tablets or drug
23 type residue.

1 Q Did you send out those tablets for testing?

2 A They were submitted to the toxicology laboratory
3 of the consolidated laboratories.

4 Q How many tablets, or residue of how many tablets
5 did you find?

6 A I did not count them.

7 Q These tablets that you submitted for toxicology t
8 testing, did you get a report back from the lab?

9 A Yes, sir. The report was tendered on January 25,
10 1977.

11 Q Did you get a further report back from the tests
12 on March 3, 1977?

13 A A supplemental report on the drug materials and
14 further examination of the blood was tendered on March 3,
15 1977.

16 Q Did you reach a conclusion during examination as
17 to the cause of death of Wing C. Chu?

18 A Final determination was salicylic acid poisoning.

19 Q Do you have a copy of the report here, Doctor?

20 A Yes.

21 Q Was this report kept at the medical examiner's
22 office in the normal course of business?

23 A That's correct.

1 A No.

2 Q The Court indulge me.

3 Doctor, I don't want to go back over it, but I
4 want to ask you this. I take it you are not able to
5 formulate an opinion, albeit not absolute or definite, but
6 just within the realm of reasonable medical probability,
7 first of all, on the level of the Salicylic Acid in the lad's
8 system as to, say, 10:10 the night of the admission?

9 A I made no attempt, and I would have no opinion.

10 Q You have no opinion now, is that a fair statement?

11 A I am only interested in what is in his body at
12 the time he dies. I do not have contact with him at 10:10
13 the preceding evening.

14 Q I understand that. But don't you, as a pathologist,
15 when you see there is a certain condition at autopsy or
16 whatever, isn't it a part of your consideration centered
17 around I wonder how long it's been there?

18 A It would be my opinion that if he had this level
19 at the time he died, he certainly had a toxic level, if not
20 a close to lethal level at the time he was admitted to the
21 hospital.

22 Q All right.

23 What is considered a lethal level?

1 A One cannot give an absolute figure; generally,
2 any time you move above the range of 50 - 60 mg%, you are
3 getting into a lethal range.

4 Q 50 or 60%, when you give those values, you're
5 referring to the blood level only, is that correct, sir?

6 A That's the only level you're interested in.

7 Q So, if his level was at that range or above at the
8 time he came into the hospital, then the chances are at
9 some point thereafter he was going to arrest, is that not a
10 fair statement?

11 A If allowed to go untreated, that's correct.

12 Q All right, but even with treatment, is there not
13 the probability of arrest, respiratory arrest and cardiac
14 arrest with that level, lethal or above?

15 A That is one of the complications of that level.
16 However, as I've indicated, people with this level under
17 vigorous treatment have survived.

18 Q Is there a level at which they do not survive with
19 vigorous treatment?

20 A It's a variable thing. There has been individuals
21 with extremely high level to have survived.

22 Q Isn't it true, Dr. Beyer, if there is a
23 percentage level of 80 or above, very rarely do they survive

1 under any circumstances?

2 A Again, that's an individual lived thing. It would
3 depend on whether you're referring to untreated cases or
4 treated cases. Certainly, once you get into that range of
5 80 to 100, survival is very limited.

6 Q All right, sir.

7 Now, of cour, if he had -- if he had a level of
8 100 at the time he came in the hospital at 10:10, would you
9 have an opinion as to whether or not he was doomed at that
10 point irrespective of treatment?

11 MR. HIRSCHKOP: Pardon me, Doctor. I am going to
12 object. There is no basis for an assumption of 100 or a
13 basis of 70 or 80. The doctor's repeatedly said five or
14 six times he can't give a number to the entry figure. It's
15 just totally speculative.

16 THE COURT: If you would like to respond, I will
17 hear you up here.

18 MR. SLENKER: I'm doing what I can to develop the
19 information from Dr. Beyer on the times, if you will, and
20 what his opinion is within reasonable medical probability
21 at what level, or what hours various levels would be
22 obtainable. And I just want to get what information he has.
23 If it's speculative, I think he would probably tell me it's

1 speculative.

2 THE COURT: With respect to the assumption of the
3 question, I sustain the objection.

4 BY MR. SLENKER:

5 Q All right.

6 Under what circumstances, Dr. Beyer, if any,
7 could you give us an opinion within reasonable medical
8 probability of a condition existing when the lad came into
9 the hospital as to whether he would survive with treatment
10 or without treatment?

11 MR. HIRSCHKOP: Your Honor, Again, I will object.
12 I don't think it's a proper hypothetical. If he puts in a
13 hypothetical they didn't bother testing before an hour and
14 a half, put in there for an hour and a half the child laid
15 there and they didn't do anything for him, didn't draw one
16 ounce of blood --

17 THE COURT: (Interposing) I overrule the objection.

18 You may answer that last question, sir.

19 THE WITNESS: The only thing I can again restate
20 is that I believe the individual had a toxic level at the
21 time he was admitted to the hospital and during his course
22 in the hospital developed a lethal load.

23 BY MR. SLENKER:

1 MR. HIRSCHKOP: Pardon me. I'm going to object.
2 This is totally irrelevant to this case. It's obvious he
3 doesn't want to talk about what killed this young man, but
4 that's irrelevant.

5 THE COURT: Do you wish to respond?

6 MR. WALSH: May I respond to the bench?

7 (Whereupon, the following bench conference was
8 held out of the hearing of the jury.)

9 MR. WALSH: Do you mind if the doctor steps down
10 while I discuss this matter?

11 THE COURT: Would you step down just for a moment.

12 MR. WALSH: Your Honor, an important aspect of
13 the qualifications of this doctor and credibility of this
14 doctor and the believability this doctor's testimony, I think,
15 rest upon some of the assertions he made about his
16 qualifications and his knowledge of the standard. And he
17 clearly testified that he talked to the doctor or doctors in
18 Virginia in order to become familiar with that state. I
19 think I am entitled to explore that without getting into
20 privileged information. I'm not interested in getting into
21 who the patient was or what the problems were. But the
22 circumstances, I think, are relevant, particularly inasmuch
23 as I believe that Dr. Cravis and Dr. Spilker have had this

1 MR. HIRSCHKOP: Can I impose my own objection.
2 My experience has always been the set procedure of examination
3 at the trial, and don't keep switching around. Could they
4 designate who's going first or second?

5 THE COURT: We've always had Mr. Walsh going first.
6 I was going to see if they wanted to switch, but Mr. Walsh
7 has always gone first.

8 Whichever one of you does direct examination, that
9 person continues with the witness and also handle the
10 objections.

11 MR. SLENKER: Your Honor -- if he's finished.

12 MR. HIRSCHKOP: I wasn't, except at the bench since
13 both are here, may I be allowed to address the Court not
14 before the jury?

15 THE COURT: Yes, at the bench you may.

16 MR. SLENKER: One other objection.

17 When an objection is made as was just made by Mr.
18 Hirschkop, it's unnecessary and uncalled for and improper for
19 him to make statements they're obviously not interested in
20 what killed this child which is totally unrelated.

21 THE COURT: Would you not make those remarks in
22 front of the jury. You may make them up here, if you are
23 going to do that, but not in open court.

1 clinical findings and the tests?

2 A I think this whole case is about medical judgment,
3 sir.

4 Q And the determination --

5 MR. SLENKER: (Interposing) Excuse me, Mr. Walsh,
6 I didn't catch that.

7 THE WITNESS: I think the entire issue is about
8 medical judgment, I would agree.

9 MR. SLENKER: I see.

10 BY MR. WALSH:

11 Q So, in this case the decision to take the serum
12 salicylate level test was a matter of medical judgment to be
13 exercised by the physician in the clinical situation, isn't
14 that correct, doctor?

15 A Yes, it is a matter of judgment.

16 Q Doctor, you also said late in your testimony that
17 your opinions as to the deviation from the standard of care --
18 and you called them serious or major violations of the standard
19 of care in certain instances was an opinion arrived at by
20 your professional experience in treating aspirin overdose
21 patients and your training since you left medical school many
22 years ago, didn't you?

23 A Yes, sir.

1 and have the stomach pumped?

2 A Well, yes, I told her take the child over to the
3 emergency room. I called the hospital and spoke to the house
4 physician there and told him what was coming in so they knew.

5 Q You told them about the child having ingested the
6 aspirin and you wanted the stomach pumped?

7 A Or make the child vomit; whatever they felt best.

8 Q Vomiting would be one of the modalities?

9 A In some cases.

10 Q You had, albeit a very limited history, but a very
11 salient and meaningful history with regard to what had been
12 consumed over what period and during what period it had been
13 consumed. And you knew to send them to the emergency room,
14 and you knew the specific there or the maneuver that ought to
15 alleviate the situation, didn't you?

16 A Yes, sir.

17 Q Would you concede, Dr. Cravis, in that respect and
18 with that case your information was fully significant by way
19 of a history, and that the information given in this case
20 that we're trying here was woefully lacking in significant,
21 meaningful information?

22 A Well, I'm not going to concede to all those parts
23 of it.

1 Q Tell us what part you can't concede.

2 A I can concede when somebody walks into the emergency
3 room and walks down with a bottle of aspirin in their hand,
4 and the bottle is empty, certainly it's a lot easier and
5 nicer than when somebody comes and you haven't got the
6 history. But it's also a fact many patients who do take
7 overdoses of drugs come in and lie about it because they are
8 embarrassed about that. They will complain about something
9 entirely different.

10 Now, that doesn't mean the doctor has -- the doctor,
11 according to the standard of good medical care cannot make an
12 error. But he still has an obligation to work this patient
13 up based upon clinical findings when he knows what proper
14 studies to do at the proper time.

15 Q I understand.

16 Of course, this man didn't come in holding a
17 bottle of aspirin, did he?

18 A No, obviously not.

19 Q As a matter of fact, wouldn't you have to concede
20 the history that was given by the patient was of no real
21 significance or meaning to the people they asked for help in
22 this case?

23 A History of vomiting, I think, is very significant.

1 Q What else is significant?

2 A I think that's significant.

3 Q Vomiting?

4 A Vomiting is significant in regard to the fact this
5 patient is dehydrated.

6 Q You see a history of vomiting and you see an
7 autopsy where aspirin material is still in the stomach
8 contents. Are you still saying that's significant, vomiting
9 is significant item of history in connection with this
10 patient?

11 A It's significant in regard -- in conjunction with
12 all the other things you can learn. I didn't mean to imply
13 to you when the patient came in at 10:10 you could snap your
14 fingers and say aspirin poisoning. You have to consider
15 the whole differential diagnoses. But to say you must also
16 concede that the history of vomiting can be rather significant,
17 just as a history of excessive sweating and perspiration.
18 This may account for dehydration in the patient, or compounding
19 the hydration. All of this is important, not any just one
20 single thing.

21 Q About the dehydration now, I believe you tied that
22 in with the ability of the kidneys to retain as much of the
23 moisture and the liquids as the body could. Is that a fair

1 to find out what's going on. That's why you have to do the
2 electrolytes in a hurry, and the blood gases. You have to
3 find out what the imbalance is and where it is.

4 Q While you're trying to ascertain that, that involves
5 medical judgment, doesn't it?

6 A Yes, sir, it involves medical judgment.

7 Q I believe you testified this entire case is about
8 medical judgment?

9 A Yes, sir.

10 Q And I take it from your testimony on direct
11 examination that it is your view and your opinion that there
12 were numerous errors in the judgment made here?

13 A Yes, sir, there were numerous errors in judgment.

14 Q That would be on the part of all the personnel that's
15 involved in the care of the patient?

16 A I'd think you'd have to be a little more specific.

17 Q Does that apply to the nurses?

18 A Well, yes, I think it does.

19 Q Does it apply to the doctors that were attending?

20 A Yes, it does.

21 Q So, they were guilty of what you say are errors in
22 their medical judgment, right?

23 A Yes.

1 Q Indeed, that's what this entire case is all about,
2 is it not, sir?

3 A Yes.

4 Q All right.

5 Now, then, you mentioned the fact -- let me ask
6 you this.

7 Do you assume from the fact that the doctor asked
8 for alcohol levels and barbiturate levels that he was thinking
9 overdose?

10 A Yes, sir, that seems rather apparent.

11 Q All right.

12 Do you think that he failed or in some manner
13 exercised or committed an error in judgment because he did
14 not think of aspirin?

15 A Yes, sir, I think he did make an error in judgment
16 because he thought of barbiturates, not of aspirin.

17 Q Could you agree, Doctor, that cases of aspirin
18 overdose, while very common in the age group of one to three,
19 or one to four, or ages one to five are pretty common, but
20 in the sixteen year old age group they are not common?

21 A I think that's irrelevant. It's still one of the --

22 Q (Interposing) Would you just answer my question,
23 sir.

1 Q Do you have an opinion, Dr. Cravis, in connection
2 with this case as to how many aspirin tablets were, in fact,
3 ingested by this patient?

4 A Well, I have an opinion there was probably, at
5 least, fifty. Beyond that, I can only guess.

6 Q At least fifty of them?

7 A I would guess.

8 Q Do you have an opinion as to whether they were taken
9 at one time?

10 A I have no opinion about that. I have no information
11 on which to make an opinion.

12 Q Do you have an opinion as to any number of the total
13 you gave us was given or was taken?

14 A Well, the only opinion I could give there was the
15 fact, looking back at the pathology report, that there were
16 seventeen undisgested tablets. One would have to pretty much
17 say those seventeen were taken at the same time, if not more.

18 Q Do you assume that the seventeen that were mentioned
19 in the pathology in the stomach were part of the fifty that
20 you have the opinion were taken?

21 A It's possible. I have no way of knowing any of
22 this information.

23 Q Do you believe that you reached the peak benefits

1 contemplation staphylococcus?

2 A Staphylococcus is a well known bacterial cause
3 of infection.

4 Q Causes infection, causes serious infection?

5 A It can cause a very serious infection.

6 Q A severe infection?

7 A It can cause very minor ones, too.

8 Q Can it cause a difference in the arterial blood
9 gases?

10 A Generally, it can cause a complete acidosis problem.

11 Q A complete acidosis problem?

12 A There would be metabolic acidosis as if you were
13 talking about something to do with sepsis. There would be
14 no component balancing out the two things we are talking
15 about here.

16 Q You would have another pathological condition that
17 would account for that condition rather than what we have
18 here, is that what you're saying?

19 A I'm sorry, I am saying the blood gases would not
20 be as they are. They would not be reflective of a
21 staphylococcus infection.

22 Q If you had a staphylococcus infection, indeed, in
23 the lungs, would that be sufficient to cause your acidosis