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IN THE

SUPREME COURT OF VIRGINIA

AT RICHMOND

770752

MARGARET A. NOLL, As Administrator
of the Estate of DAVID GLENN NOLL,
Deceased

Appellant

V.

FREDERICK RAHAL, M. D., And
MICHAEL JAFFE, M. D.

Appellees

APPENDIX

Abraham J. Dere
Of Counsel for Appellant

CANTOR AND CANTOR
3300 West Broad Street
Richmond, Virginia 23230

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(Caption Omitted)

MOTION FOR JUDGMENT

TO THE HONORABLE JUDGES OF THIS COURT:

The Plaintiff hereby moves this Honorable Court for a judgment against the Defendants, jointly and severally, for the sum of $1,075,000.00, which amount is due and owing by the Defendants as a direct and proximate result of the following damages and wrongs:

1. Margaret A. Noll has duly qualified as the administrator of the estate of David Glenn Noll, deceased, in the Circuit Court of Henrico County, Virginia, on June 4, 1974, as evidenced by a copy of a Certificate of Qualification hereto attached.

2. The Defendants, Frederick Rahal and Michael Jaffe, were at the time mentioned below and still are physicians engaged in the practice of pediatric medicine in the County of Henrico, Virginia, being duly licensed under the laws of this Commonwealth.

3. On or about Monday, May 20, 1974, your Plaintiff (Margaret A. Noll) did take her twelve year old infant son, the decedent, (David) to seek and obtain medical treatment for compensation from Doctors Jaffe and Rahal, who maintained offices for the practice of medicine at 5901 Lakeside Avenue, Henrico County, Virginia.

4. On the said 20th day of May, 1974, at approximately 10:00 a.m., David was examined by Dr. Michael Jaffe, at which time the said Dr. Michael Jaffe did not use the care and skill ordinarily used by physicians engaged in the specialty of pediatric medicine

in the County of Henrico, Commonwealth of Virginia, or in similar localities. Although David had symptoms indicating that he had Rocky Mountain Spotted Fever, said symptoms being high fever, viral infection present in and enlargement of glands in throat, and tick bites on his body; nevertheless, Defendant negligently and incorrectly diagnosed David's condition as measles and instructed David's mother, said Margaret A. Noll, to feed David fluids and Tylenol.

5. During the next several days, the Plaintiff was in contact with Doctors Jaffe and Rahal concerning the condition of her son David, and apprised the said physicians of symptoms consisting of continuous high fever, failure to keep food down, vomiting, frequent trips to bathroom, aching ribs and stomach, and body rashes. Doctor Rahal also advised Mrs. Noll that he was certain David's condition was measles, the same diagnosis rendered by Doctor Jaffe. On May 26, 1974, David went into a convulsion and was hospitalized.

6. On May 26, 1974, at approximately 2:45 p.m., Doctor Rahal carelessly and negligently hospitalized David at St. Mary's Hospital; said hospital not having proper medical equipment and/or diagnostic facilities or personnel to treat him, authorities at St. Mary's Hospital had David transferred to Medical College of Virginia at approximately 8:00 p.m. that evening. A prudent physician under the same circumstances would have hospitalized the decedent at the Medical College of Virginia Hospital-Virginia Commonwealth University.

7. As a result of this delayed diagnosis and treatment, David was in such an advanced stage of Rocky Mountain Spotted Fever that proper treatment could not be administered and the decedent died at Medical College of Virginia Hospital, Richmond, Virginia, at approximately 12:25 a.m., on May 28, 1974.

8. Had Defendants, Rahal and Jaffe, used proper methods of examination, they would have discovered that Plaintiff was suffering from Rocky Mountain Spotted Fever, which required immediate prescription of medication stronger than Tylenol, aspirins, or suppositories to effect a cure.

9. The death of Plaintiff's decedent is directly attributed to the careless and negligent wrongful diagnosis made by Defendants, Rahal and Jaffe, because with appropriate and timely diagnosis, proper therapeutic intervention should have resulted in the recovery of Plaintiff's decedent instead of his untimely demise.

10. The other Defendant named herein, i. e., St. Mary's Hospital of Richmond, Inc., although holding itself out as a general hospital, failed to have proper equipment and/or to take necessary emergency measures to combat and effectively treat the Rocky Mountain Spotted Fever of the decedent.

11. As a proximate result of Defendants' negligence aforesaid, the Rocky Mountain Spotted Fever reached an advanced stage, and as a direct and proximate cause of the aforesaid negligence, David subsequently died at the time and place stated aforesaid.

12. As a further proximate result of the Defendants' negligence aforesaid, decedent's mother incurred large funeral expenses, has lost the comfort, society and counsel of her son, who was a young child of good habits and a devoted and loving son. She has lost the future services of her son in assisting her and caring for her in her later years. She also lost support which her son would give her based on his powers of future earnings and acquisitions and on the position in society he would have occupied in the future.

WHEREFORE, your Plaintiff asks that Judgment be rendered in her behalf in the sum of $75,000.00 for the wrongful death of her son and decedent, David Glenn Noll, and for the sum of $1,000,000.00 as punitive damages.

MARGARET A. NOLL, Administrator
of the Estate of DAVID GLENN
NOLL, Deceased
By Robert Cantor
Counsel

Robert Cantor, Esquire
CANTOR AND CANTOR
3300 West Broad Street
Richmond, Virginia 23230

(Filed May 11, 1976)

(Caption Omitted)

DEMURRER AND GROUNDS OF DEFENSE
OF
FREDERICK RAHAL, M. D.
AND
MICHAEL JAFFE, M. D.

DEMURRER

The defendants, Frederick Rahal, M. D. and Michael Jaffe, M. D., by counsel, demur to that portion of the Motion for Judgment which claims punitive damages, as it fails to state a cause of action upon which relief can be granted.

GROUNDS OF DEFENSE

The defendants Frederick Rahal, M. D. and Michael Jaffe, M. D., by counsel, deny that they owe the plaintiff the amount sued for, or any amount, for the reasons stated or for any reason, and for their Grounds of Defense state as follows:

1. They admit the allegations of paragraphs 1, 2 and 3 of the Motion for Judgment.

2. They admit that Dr. Jaffe examined the decedent on May 20, 1974, however the remaining allegations of paragraph 4 of the Motion for Judgment are denied, and it is further denied that Dr. Jaffe was guilty of any negligence in his care and treatment of the plaintiff's decedent, on that occasion or otherwise.

3. They admit that they subsequently rendered care and treatment to the decedent and that on or about May 26, 1974, he was admitted to St. Mary's Hospital and then to Medical College of Virginia Hospital, where he later died, however they deny the remaining allegations of paragraphs 5, 6 and 7 of the Motion for Judgment.

4. They deny the allegations of paragraphs 8 and 9 of the Motion for Judgment and specifically deny that they were guilty of any negligence in the care and treatment of the plaintiff's decedent which was the proximate cause of his death, either in the particulars alleged or otherwise.

5. They neither admit nor deny the allegations of paragraph 10 of the Motion for Judgment, as the allegations contained therein are unknown to these defendants.

6. They deny the allegations of paragraphs 11 and 12 of the Motion for Judgment, and specifically deny that they were guilty of any negligence which was the proximate cause of the death of the plaintiff's decedent, and further deny that the plaintiff has suffered any of the injuries, damages or disabilities complained of.

7. They aver that the plaintiff was herself guilty of negligence which efficiently contributed to cause the death of her decedent.

8. They will rely upon any and all other properly provable defenses to this action and reserve the right to amend their Grounds of Defense if they be so advised.

WHEREFORE, defendants Rahal and Jaffe pray for judgment in their favor and their costs expended herein.

(Certificate Omitted)

FREDERICK RAHAL, M.D.
MICHAEL JAFFE, M.D.
By R. Carter Scott, III
Counsel

R. Carter Scott, III
BROWDER, RUSSELL, LITTLE,
MORRIS & BUTCHER
1200 Ross Building
Richmond, Virginia 23219

(Filed - May 24, 1976)

(Caption Omitted)

O R D E R

Came again the parties, by counsel, on Demurrers filed by all defendants, and with consent of counsel for the plaintiff, the Court doth ORDER that said Demurrers be sustained and that any claim for damages in excess of Seventy-Five Thousand Five Hundred Dollars ($75,500.00) plus incidental medical expenses should be stricken from the Motion for Judgment.

ENTER: 12/13/76

Edmund W. Hening, Jr.

We ask for this:

R. Carter Scott, III
Counsel for Frederick Rahal, M.D.
and Michael Jaffe, M.D.

Lanier Thurmond
Counsel for St. Mary's Hospital

Seen and Consented to:
Robert Cantor, p.q.

(Caption Omitted)

O R D E R

On motion of the plaintiff, by counsel, this case is hereby nonsuited as to the defendant, St. Mary's Hospital of Richmond, Inc., and remains on the Court docket solely against the defendants, Frederick Rahal, M.D. and Michael Jaffe, M.D.

ENTER: 2/14/77

Edmund W. Hening, Jr.
Judge

Requested:

Robert Cantor, p.q.

Seen:

Lanier Thurmond, p.d.
Counsel for defendant,
St. Mary's Hospital of
Richmond, Inc.

(Caption Omitted)

O R D E R

This day came the parties in person and by counsel, and the defendants having heretofore filed their Grounds of Defense herein, issue is joined.

On February 14, 1977, this matter was non-suited as to the defendant St. Mary's Hospital of Richmond, Inc.

Wherefore, came a jury, to wit: Robert J. Grady, Dorothy C. Brown, George M. Burton, Edward H. Bragg, Leon Baldwin, Nathan H. Young, Jr., and Lois A. Chandler who were sworn to well and truly try the issue joined and a true verdict give according to the evidence.

After hearing the evidence of the plaintiff, the jury was adjourned until February 16, 1977, at 10:00 A.M.

After hearing argument of counsel, the Court for reasons stated to the record ruled that the damages sued for in the amount of $75,000.00 be reduced to $25,000.00 as allowed by the 1968 statute.

Whereupon Court was adjourned until 10:00 o'clock A.M. on February 16, 1977.

ENTERED 2/15/77

(Signatures omitted)

(Caption Omitted)

FINAL ORDER - CASE NO. 76L166

Pursuant to adjournment, came again the parties in person and by counsel, and came also the jury which had been previously empaneled and sworn.

The attorney for the plaintiff, outside the presence of the jury, moved the Court to reconsider its ruling concerning the competency of the testimony of Dr. Kramer, which motion was overruled and exception noted.

Thereupon, the plaintiff rested, and counsel for the defendants moved to strike the plaintiff's evidence and to enter summary judgment for the defendants for the reasons stated to the record, which motion was sustained, and summary judgment was granted for the defendants, to which ruling the plaintiff, by counsel, objects and excepts.

Thereupon, the plaintiff, by counsel, moved to set aside the judgment as being contrary to the law and evidence and to order a new trial, which motion was overruled, and exception noted.

Thereupon, the jury was returned to the courtroom and were discharged.

It is therefore ordered that the plaintiff take nothing and that judgment be entered in favor of the defendants.

ENTERED: 2/16/77

(Signatures omitted)

(Caption Omitted)

NOTICE OF APPEAL AND

ASSIGNMENTS OF ERROR

The Plaintiff, Margaret A. Noll, Administrator of the Estate of David Glenn Noll, Deceased, by counsel, hereby gives notice of its intention to appeal from the Final Judgment and Order of the Circuit Court of the County of Henrico, herein entered on the 16th day of February, 1977, and assigns the following as error:

1. That the Court erred in ruling that Lloyd I. Kramer, M. D., Plaintiff's witness, was not qualified to testify as an expert witness.

2. That the Court erred in ruling that it did not consider Lloyd I. Kramer, M. D., as being familiar with the standards of medical practice of pediatricians in the Richmond metropolitan area or similar communities.

3. That the Court erred in striking out the testimony of Lloyd I. Kramer, M. D.

4. That the Court erred in sustaining Defendants' Motion to Strike the Plaintiff's evidence and to enter Summary Judgment for the Defendants.

Plaintiff intends to file a transcript and incidents of trial as part of the record on appeal.

MARGARET A. NOLL, Administrator
of the Estate of DAVID GLENN
NOLL, Deceased
By Abraham J. Dere
Counsel

Abraham J. Dere, Esquire
Robert Cantor, Esquire
CANTOR AND CANTOR
3300 West Broad Street
Richmond, Virginia 23230

(Certificate Omitted)

(Filed - March 1, 1977)

EXCERPTS FROM OPENING STATEMENTS

Statements by Mr. Scott

(tr 28) * * *

They will testify that there are no reliable tests early in Rocky Mountain spotted fever to diagnose that condition. You can't send the patient to a laboratory and say, take some blood and we want to find out whether or not it's Rocky Mountain spotted fever. * * * We know that he did, and we have agreed that he did. * * *

* * *

(tr 29) * * *

* * * In fact, the evidence will show you that in the year 1972 there was one case of Rocky Mountain spotted fever in the County of Henrico during the whole year. There were none in 1972, there were no indications of Rocky Mountain spotted fever in the County of Henrico. In 1973 there were no indications of Rocky Mountain spotted fever in Henrico County. In the whole county for the year of 1974 there was one reported case of Rocky Mountain spotted fever, and that was this one. * * *

* * *

EXCERPTS FROM TESTIMONY

(tr 18) * * *

LLOYD KRAMER, a witness * * *

DIRECT EXAMINATION

BY MR. CANTOR:

Q. Would you please state your name to His Honor and the members of the jury, Doctor.

A. Lloyd Kramer.

Q. What is your residence, Dr. Kramer?

A. McLean, Virginia.

Q. How old are you, sir?

A. Thirty-six.

Q. Now, will you tell us about your undergraduate education.

A. Yes. I attended the University of Maryland Undergraduate School in College Park, Maryland in '58-'62, and the University of Maryland Medical School in 1962-1966.

Q. Did you get a degree from the University of Maryland, sir?

A. Yes, sir.

Q. Would you tell us what those degrees are.

(tr 19) * * *

A. A Bachelor of Science in 1962 and a Doctor of Medicine in 1966.

Q. Where did you intern?

A. My internship was a straight pediatric internship at Sinai Hospital in Baltimore, Maryland.

Q. Did you have any further medical education after your internship?

A. Yes. My second year of residency in Pediatrics was at the same Sinai Hospital in Baltimore, and the third year of residency at the University of Florida Hospital in Gainesville, Florida.

Q. Did you serve in the Armed Services for any period?

A. Yes, after that I had two years in the Air Force at Charlotte Air Force Base in Sumter, South Carolina.

THE COURT: You finished that at what time?

THE WITNESS: 1971.

Q. What type of medical practice did you have while you were in the Armed Forces?

A. I was doing a pediatric practice in the Armed Forces.

Q. What was your next position?

A. I did a fellowship in Newborn Medicine from 1971-1973 at Georgetown University in Washington.

Q. Subsequent to that, what position did you

(tr 20) * * *

take, sir?

A. I have been Director of Nurseries at the Fairfax Hospital in Falls Church, Virginia.

Q. Are you presently in that position?

A. Yes, I am.

Q. How long have you been there?

A. Since 1973.

Q. Now, are you Board certified in any specialty of medicine?

A. Yes, I was Board certified in Pediatrics in 1972, and in Newborn Medicine in 1975.

Q. Can you tell us what Board certification means?

A. It means that you have met written, and in some cases, oral standards and testing.

Q. For a specialty of medicine?

A. For a specialty of medicine.

Q. Have you published any publications?

A. Yes, in 1969 in the American Diseases of Children, in 1975 in the Journal of Pediatrics, and in 1976 in the Journal of Pediatrics.

Q. Are you familiar with the standard of care used by physicians who practice pediatric medicine in the metropolitan area of Richmond beginning say in 1974, the spring of 1974, before May? (tr 21) * * *

A. Yes.

Q. In the practice of pediatric medicine is there a type of involvement with diseases called endemic diseases?

A. Yes, there is.

Q. Would you tell us what endemic diseases mean and give us an illustration of some of them.

THE COURT: Would you spell the term.

THE WITNESS: E-n-d-e-m-i-c.

Q. Go ahead.

A. Endemic implies that a particular illness is more likely to occur in a certain locality. For example, the condition: Rocky Mountain spotted fever. It has the name Rocky Mountain, implying that it occurs in that area, anyplace that ticks reside the disease may occur there also, and it is very common therefore in the Atlantic Coast states.

Q. Can you tell us about what infectious agents are?

A. There are three common infectious agents that we deal with all the time. The first is viral, which are the smallest of the infectious particles. These agents generally are very widespread in the community. All age groups are affected, children have a more predisposition to them than older age groups just because they have had no previous experience. The viruses generally do not have any

(tr 22) * * *

specific treatment in the form of antibiotics or any other such drugs, and for the most part you can only treat the symptoms of the viral infections and some of the complications that arise from them.

The rickettsial agents are intermediate in size to viruses, and they--

THE COURT: Excuse me, may I have the spelling of rickettsial.

THE WITNESS: R-i-c-k-e-t-t-s-i-a-l.

THE COURT: Thank you.

Q. Go ahead.

A. These are intermediate agents that are also infectious. They are a bit bigger than the virus, they can be seen with a standard microscope whereas the virus cannot. These agents generally have a treatment in the form of antibiotics. If instituted at the proper time often the condition can be reversed, or the person's illness can be terminated, or modified in such a way that they can recover from it.

The bacterial infections are the other agents that we commonly come in contact with, and these agents are larger, they can be seen with the standard microscope. These agents again affect all age groups. They are very commonly secondary infections to viral illnesses which have already damaged tissue, and can be a complication of

(tr 23) * * *

viral illnesses, or they can themselves cause primary illnesses. These also have the capability of being modified by antibiotics and the course of the illness shortened or terminated by the use of antibiotics.

Q. Doctor, does the appearance of a rash have any significance to a practitioner of pediatric medicine on a patient?

A. The rash, when it appears, can sometimes help you distinguish one type of illness from another. There is no rash that is absolutely classic for any one disease. There is a fair amount of overlap, but certain types of rashes that you see have significance that suggest one type of illness may be more likely than another.

When the rash appears in the course of the illness this will sometimes give you a clue as to what type of illness you have. Where it starts on the body, whether it starts on the face and chest or whether it starts on the hands and feet and works up, will also have some significance, and also what it looks like.

The rashes can be in the form of just a flat type of rash, called a macular rash; a raised, bumpy type of rash, called a papular rash; when it has water associated with it, it can either be called vesicular or bullous, depending upon how big the lesions are; and then the other phase is called pustular, when the sacs have some

(tr 24) * * *

pus in them. These are the four most common type of rashes, and whether or not they have redness associated with them at the base is also very useful.

So, the type of rash and where it is located and what phase of the illness it occurs in can be very helpful in differentiating different types of illnesses.

Q. Can you tell us the difference between a specific or a definitive diagnosis by a pediatrician or a doctor, and a differential diagnosis?

A. A specific diagnosis implies that all the information that you have about the patient, the history, the physical findings, and the laboratory findings are all conclusive that one diagnosis

is guaranteed and you can be confident that you have all the information that says that diagnosis is without doubt.

When the information that you have leading up to the diagnosis is so broad or so nonspecific that you can't be sure that you have one particular type of illness, then you have to consider a differential diagnosis which will encompass many different possibilities, especially including those possibilities that are in need of treatment, ones that can be modified by your treatment and perhaps be prevented from becoming more serious or having a lethal outcome.

Q. Do you mean that when you have a differential

(tr 25) * * *

diagnosis that you should treat the treatable fatal type of diagnosis?

MR. SCOTT: Your Honor, we object to that question as being leading.

THE COURT: Yes, that is a leading question.

Q. Can you tell us whether or not it makes a difference whether you have a fatal disease or a likely-to-be fatal disease within your differential diagnosis?

A. If one of the diseases in this differential diagnosis--

MR. SCOTT: Excuse me just a moment, Your Honor. I apologize for the further delay, but it appears that we are getting into a question of expert testimony and the standards of practice, and I would at this time move the Court to exclude such opinions on the basis that the physician has not been qualified to testify or has

not been qualified as to his knowledge of the standard of practice in this community or in similar communities in May of 1974, and with the understanding that if the Court feels that his statement is sufficient that I be allowed the latitude to examine him on the basis for his qualifications and opinions since it appears that we are now getting into that area.

THE COURT: I think the objection is

(tr 26) * * *

appropriate and the request is proper.

Mr. Cantor, I will allow you to make any further inquiries into his background that you wish, and then before you get to any specific question the defense counsel will be permitted to cross-examine him on his familiarity with the community standards in this area or any similar area.

MR. CANTOR: Do you want me to proceed along that line?

THE COURT: Yes, before we get to any specific question.

BY MR. CANTOR: (Continuing)

Q. Dr. Kramer, in response to a previous question you have said that you are familiar with the standard of care used by physicians practicing pediatric medicine in Richmond in May of 1974, is that correct?

A. Yes.

Q. Will you please tell us the basis of your familiarity and how you tell us that you are familiar with these practices.

A. Okay. First, I am a member of the Medical Society of Virginia, and one of the monthly publications that they send out

is the Virginia Monthly, it is a journal, which has articles written by Virginia physicians that encompass pediatrics and all phases of medicine, and these would lend

(tr 27) * * *

themselves to what is felt to be the proper standard of care for physicians practicing in the State of Virginia. I also attend meetings and participate in meetings throughout the state periodically, which allows me to interact with physicians from all parts of the state and hear what their criteria for proper medical care is. Also, add to that that I will be attending the Academy of Pediatrics, Virginia Chapter, at their annual meeting in about two weeks in which I will be participating in the conference. The third point is the fact that I am teaching at Fairfax Hospital the Medical College of Virginia family practice residents.

THE COURT: Just a moment. Teaching where?

THE WITNESS: At the Fairfax Hospital in Falls Church, Virginia. I am teaching family practice residents, in which standard pediatric problems are taught.

THE COURT: I am sorry, I did not hear what you are teaching.

THE WITNESS: I am teaching family practice residents from the Medical College of Virginia.

THE COURT: Who are the students?

THE WITNESS: These are medical residents.

THE COURT: All right, go ahead.

Q. Where are these medical residents from?

A. From Richmond.

(tr 28) * * *

Q. From Richmond?

A. Yes.

Q. Do you have discourse with doctors in charge of the teaching program at the Medical College of Virginia as a result of this teaching?

A. Yes.

Q. This course, I take it, is in reference to pediatric medicine?

A. Yes.

MR. CANTOR: I submit that that qualifies Dr. Kramer as to his familiarity with the practice of pediatric medicine in the metropolitan area of Richmond.

THE COURT: Do you wish to cross-examine?

MR. SCOTT: Yes, sir.

CROSS-EXAMINATION

BY MR. SCOTT:

Q. Dr. Kramer, your initial experience with the practice of medicine of any type in the State of Virginia began in 1973, did it not?

A. That's correct.

Q. And prior to that time your medical background was in other states, correct?

A. I also had some training experience in

(tr 29) * * *

Virginia through my fellowship in 1971-1973 while I was at Georgetown, that's in a training capacity.

Q. In Washington?

A. In both Washington and Northern Virginia.

Q. You said that that was in newborn medicine?

A. Yes.

Q. Is there a time limitation where that stops and pediatric starts?

A. It's a nebulous limitation in the sense that it can be anywhere from the first few days of life anywhere up to six months.

Q. But, basically speaking, after the six months you are out and the pediatrician comes in?

A. I am a pediatrician.

Q. I understand that, but your fellowship involved the first six months of life primarily?

A. It words in that area primarily, yes.

Q. Your position at the Fairfax Hospital is Director of Nurseries, correct?

A. Yes.

Q. And that involves newborn infants?

A. Yes.

Q. Does that involve the six-month period, or is it shorter?

A. It can go up as long as the six months,

(tr 30) * * *

it doesn't necessarily limit me to that age group, I will occasionally see older children on consultation, but it's primarily in that age group.

Q. Your medical practice since 1973 has primarily been limited to the care and treatment of newborn infants?

A. Yes.

Q. What was the date in 1973 that you began that?

A. July of '73.

Q. Am I correct in assuming that between July of '73 and May of '74 that you were not in the private practice of pediatrics in the State of Virginia?

A. I wasn't in the private practice of pediatrics. Pediatrics encompasses all age groups from birth on up, so I would have to consider myself in the practice of pediatrics.

Q. Did you have an office outside of the hospital?

A. No, my office is within the hospital, but I do see private patients there.

Q. Do you see these patients primarily in consultation or primarily as private patients?

A. Primarily in consultation.

Q. And this is primarily in regard to newborns?

(tr 31) * * *

A. Yes.

Q. Did you treat any patients that were over six months old from July of '73 until May of '74?

A. Yes.

Q. How many, approximately?

A. A very limited number.

Q. This would be only in consultations from other physicians?

A. Yes.

Q. Did you see any patients or treat any patients for Rocky Mountain spotted fever during that time?

A. During that time, no, sir.

Q. Have you ever treated a patient for that?

A. Yes, I have.

Q. Approximately what date?

A. During my pediatric training there were cases, and also between the years 1969 and 1971.

Q. No, sir, my questions are completely with reference to since you came to Virginia.

A. No.

Q. You have not treated any patients for that?

A. No.

Q. Have you seen any patient with that since you came to Virginia?

A. No.

(tr 32) * * *

Q. Have you seen or treated any patients for measles since you came to Virginia?

A. Yes, I have seen.

Q. Have you treated any?

A. No.

Q. Were these patients newborns or were they older?

A. Older.

Q. Were they within six months?

A. No.

Q. Could you give us some idea as to the approximate number of patients you have seen with measles?

A. It's a limited number. The state of measles right now is such that you don't see that many cases throughout the year.

Q. Were these cases referred to you by another physician for some reason?

A. Well, these were cases that were either in the hospital or just children in the community that I came in contact with.

Q. But, was it contact upon referral from a physician?

A. No.

Q. You just happened to be passing by?

A. Or the case was being presented. In other

(tr 33) * * *

words, even though I am not necessarily directly involved with the care of patients, when you attend to rounds, or conferences, or other such activities daily you will come in contact with cases of different types.

Q. Well, what I am trying to determine, sir, is that as I understand what you are telling us, you are not or have not been since July of 1973 within the State of Virginia primarily engaged in the practice of pediatrics of infants over six months of age, is that correct?

A. Primarily, that's correct.

Q. I assume I am correct in saying that you have not practiced your specialty or any medical specialty in the City of Richmond, or the county of Henrico County, Virginia?

A. Correct.

Q. The resident program that is at the Fairfax Hospital, they are not medical students but they are residents that are in the training program at the Medical College of Virginia in family practice?

A. Correct.

Q. As opposed to residents in pediatric practice?

A. Correct.

Q. Is this instruction primarily involved or totally involved in newborn medicine?

(tr 34) * * *

A. Most of the teaching I do with either the Medical College of Virginia residents or residents from Georgetown University, or medical students, will be primarily newborn care; but, I am not limited to newborn teaching. I will teach other phases of pediatrics.

Q. In point of fact, is it limited to newborn medicine?

A. It is not limited to newborn medicine, no.

Q. Are there other pediatricians on the staff of Fairfax Hospital that participate in this instruction program?

A. Yes.

Q. And they are pediatricians?

A. Yes.

Q. And they teach older pediatric medicine?

A. Yes.

Q. You indicated that the fact that you read publications of the Medical Society of Virginia, specifically dealing with pediatrics, and that you attend meetings of pediatrics and other societies in the State of Virginia in your judgment qualifies you to know and to render a judgment as to the standard of practice of pediatrics in the County of Henrico and the City of Richmond in May of 1974 as it relates to the diagnosis and treatment of Rocky Mountain spotted fever; is that correct?

(tr 35) * * *

A. Yes, I think so.

Q. You think so? Are you sure about that?

A. Yes, I am sure about that.

Q. Which publications do you rely on?

A. The common ones are the Journal of Pediatrics, the--

Q. I am sorry, the Virginia publications.

A. The only one I read primarily in Virginia is the Virginia Monthly.

Q. The Virginia Monthly?

A. Yes.

Q. Did you start reading that in July of '73 when you came to Virginia?

A. Yes, sir.

Q. Can you recall any specific articles on the management of patients with Rocky Mountain spotted fever in that periodical?

A. No, I cannot specifically remember that particular topic.

Q. Can you remember any meetings which you have attended since July of 1973 of physicians practicing in the State of Virginia in which a discussion has been conducted concerning the management of Rocky Mountain spotted fever?

A. I cannot really answer that because I can't necessarily relate to when I have heard different things over

(tr 36) * * *

the course of the years.

Q. How many meetings would you estimate you went to between July of '73 and May of '74 that included pediatricians practicing in the City of Richmond and the County of Henrico?

A. I would say several, it's hard to be more specific than that.

Q. Are you personally familiar with any pediatricians in this community?

A. Yes.

Q. Could you name them, please.

A. David Draper, who is on the medical staff in the Department of Pediatrics at the Medical College of Virginia.

THE COURT: Are these for six months and under?

THE WITNESS: He has a general pediatric practice in addition to newborn.

Q. I am sorry, was he the only one?

A. I'm just trying to remember. There are two others that I know in this area, well, they are in Newport News and Norfolk, but I don't know if that will help very much. These two are David Marsland, and I can't remember the other fellow's name, he's in Newport News.

Q. By "the area," I meant Richmond or Henrico

(tr 37) * * *

County, Virginia. You don't know any others?

A. No.

Q. Dr. Kramer, I am concerned and I would like for you to tell us why in the event that you have never treated anyone for this disease, and that primarily your practice is limited to infants six months of age and younger, and primarily within the first several days after birth, and the fact that the publications that you refer to have not had any articles on Rocky Mountain spotted fever, and the meetings which you have attended to your knowledge have not discussed Rocky Mountain spotted fever, and that you have been primarily in the practice of newborn medicine since July of 1973, how, sir, you feel that you are qualified to judge the practice of pediatrics in this community, the City of Richmond or the County of Henrico, in May of 1974 in the management of that disease.

A. First, your statement that I have never treated Rocky Mountain spotted fever is inaccurate.

Q. Well, let's limit it to since you have come to the State of Virginia.

A. Part of your self-education, once you are a pediatrician, especially a Board certified pediatrician, is to attempt to stay current with pediatric literature; and, you are not necessarily going to limit yourself to reading only those articles that relate to newborn medicine, you are

(tr 38) * * *

going to read other pertinent articles that you think will broaden your knowledge of pediatrics. In my reading over the course of the years I have read current articles about Rocky Mountain spotted fever, what is felt to be the means by which you diagnose it, the means by which you treat it, and under certain circumstances what is the accepted medical practice for this particular illness, and that the standard of medical practice for this illness seems to be fairly uniform throughout the country. Because of my previous experience and because of my current awareness of the condition and because of my contact with physicians throughout the State of Virginia in whom I feel represent a reasonable cross-section of practicing pediatricians, I feel as though I can feel competent in assessing the treating of Rocky Mountain spotted fever.

Q. The readings that you just referred to are of publications not within the State of Virginia?

A. Correct, but they are present within the State of Virginia, they are available.

Q. And the contact that you have had with other physicians, are they limited to practitioners in the State of Virginia?

A. I don't quite follow the question.

Q. You said that you had contact with other practitioners. Are they Virginia practitioners?

(tr 39) * * *

A. Primarily Virginia practitioners. I might say that they have access to the same publications that I do, and if there is nothing available they are not going to have any additional access.

Q. Were these the physicians that you mentioned earlier, that you knew and had contact with?

A. Among others, yes.

Q. Have you ever discussed Rocky Mountain spotted fever with any of those physicians?

A. Not to my recollection, no.

* * *

MR CANTOR: I just have one further question about that, sir. Dr. Kramer, do you have to be able to diagnose and treat Rocky Mountain spotted fever and other rashes in your patients who are

(tr 40) * * *

under six months of age?

THE WITNESS: You have to evaluate rashes of infants under six months of age. Rocky Mountain spotted fever would be an outside possibility, it could theoretically occur in that age group

if a child was at home and came down with a rash of that type and came back in the hospital. So, potentially, yes.

MR. SCOTT: That's potentially true, but you haven't had any experience in that happening?

THE WITNESS: No, that's correct.

MR. SCOTT: Thank you, sir.

* * *

(tr 41) * * *

* * *

THE COURT: In other words, this is a motion preliminary to those questions which relate to any opinion by Dr. Kramer as to the standard of practice, is that correct?

MR. CANTOR: Yes, sir, as I understand it

(tr 42) * * *

that is the situation.

MR. SCOTT: Yes, sir, Your Honor.

THE COURT: All right, state your objection more fully, please.

MR. SCOTT: Yes, sir. If the Court please, the defendants by counsel would respectfully move to exclude any testimony by the present witness, Dr. Kramer, on the basis that his testimony has revealed what the defendants consider to be an inadequate and inappropriate background and qualifications for his testimony

concerning the standard of practice of the average pediatrician practicing his profession in the City of Richmond or Henrico County, Virginia in May of 1974. Without reciting Dr. Kramer's testimony, we feel that the lack of his personal familiarity and personal practice with pediatrics in general, and certainly with pediatrics over and above the age of six months, and even moreso over and above the age of several days after birth, his complete lack of personal familiarity and professional familiarity with the condition of Rocky Mountain spotted fever, his complete lack of personal familiarity with pediatricians practicing that particular specialty in the City of Richmond or Henrico County, Virginia, and that the basis for his testimony being (tr 43) * * *

the reading of certain publications of which only one was designated as relating specifically to the State of Virginia and which contained no references to the practice of pediatrics as it related to the diagnosis of Rocky Mountain spotted fever, and solely his attendance at meetings with other physicians in the Virginia area, again without any specific reference to this particular condition, would bar him from testifying about the standard of care in this locality. In the opinion of the defendants, and under the authorities heretofore mentioned, specifically the cases of Bly vs. Rhoads 216 Va. 645, and perhaps more particularly the case of Little vs. Cross 217 Va. 71, we say, even though the witness for the plaintiff has expressed his personal opinion that he is familiar with the standard, that the basis for that opinion

would be in doubt.

We would relate that this case is very similar, in our opinion, to the Little case where the testimony of a physician, although not specifically the same as this case, was excluded on the basis of nonfactual familiarity with the practice under the authorities of Bly vs. Rhoads and earlier Virginia cases which require establishment of the

(tr 44) * * *

knowledge.

We submit to the Court that Dr. Kramer's background and alleged familiarity is insufficient in this instance to qualify him to testify concerning the standard of care of this specialty in this locality.

THE COURT: Mr. Cantor?

MR. CANTOR: If Your Honor please, I think that the present case at the bar is far distinguishable from the cases cited by Mr. Scott. I think that Dr. Kramer has certainly more than adequately qualified himself as knowledgeable in the standard of care used by pediatricians in the Richmond Metropolitan Area.

The cases referred to by Mr. Scott are distinguishable in the first case, the Bly case, in that there was a physician from Pennsylvania who attempted to assert a nationwide standard of care for hysterectomies, who had never been in the State of Virginia, and the Court wouldn't apply his knowledge in the State

of Pennsylvania to Virginia. The second case, Little vs. Cross, involved an intern, or someone who had just started the practice of medicine, who was not familiar with the practice of medicine in the City of Norfolk, or wherever the

(tr 45) * * *

matter took place. He did not know the particular type of operation, it was not even being used in Norfolk at this particular time for that particular instance; whereas the present case involves a physician who is on the staff of a teaching hospital in Fairfax, Virginia, who is in contact with the teaching staff of the hospital in the City of Richmond, the Medical College of Virginia, and who enters into discourse with physicians of both areas and who is a participant in seminars held throughout the state, not only as one who listens but one who puts them on, and he has testified that he participates in pediatric seminars.

There is no showing by the defendant at this time that a particular standard of care was not used in Virginia and Richmond as opposed to Fairfax as it was in the Little case. The fact that Dr. Kramer has not personally seen a Rocky Mountain spotted fever case I think goes by defense counsel's opening remarks that there were only two in '71, none in '72, none in '73, one in '74, but the fact that he hasn't seen one doesn't mean that he is not supposed to know one when he sees one. I think the problem here is the problem of education, a problem of being knowledgeable as to what physicians who

(tr 46) * * *

practice in the area should know and what they are called on to know. This is basic education, basic to Virginia, basic to Fairfax, and basic to Richmond.

He has stated that to his knowledge he is familiar with these practices and I think that he more than qualifies and meets the tests set out in both of these cases, sir.

THE COURT: Now, Counsel, let me get back to one little technicality that I don't want us to get involved in. Mr. Cantor just made some reference to the situation in either Bly against Rhoads in 216 Va. 645, or in Little against Cross 217 Va. 71, that as of yet there was no testimony in of any other witness. That was the statement you just made, and there is some little minor reference to it in one of the cases.

MR. CANTOR: In 217 Va. 74, at the bottom of the page and the last paragraph, it is about midway of the last paragraph, it cites, for example, the uncontradicted evidence established that ultrasound, specifically relied upon by Dr. Hirsh as a non-invasive technique which should have been used by the defendant prior to performing the operation on Little, was not known in the Norfolk area at that time.

(tr 47) * * *

THE COURT: Well, what I am saying is I don't want any of us to get out on a limb purely on that particular basis. In other words, let's look at it this way, there are two or three ways to approach everything. I can say that I will take your

objection under advisement and will not allow the witness to cover this point at all at this time until the defendants put on evidence to cover the particular point that you are making. In other words, I would have to hear the defendants' evidence on this particular point beforehand. Or, I might accept or vouch the record that the defendants expect to show the technical aspect of that.

Do you see what I mean, Mr. Scott?

MR. SCOTT: Judge, perhaps I can short-circuit that. We do not intend to prove that there was any specific technique, surgical or laboratory technique, that was or was not available in Richmond or Fairfax, Virginia to diagnose this particular condition.

In other words, the defendants are not relying on a difference in surgical or laboratory techniques between the two communities to differentiate it. Our point is based on the fact that the evidence from Dr. Kramer does not establish within

(tr 48) * * *

reasonable latitude his familiarity with the practice of pediatrics in general and specifically in this community or in similar communities, and there has been no evidence from him concerning whether or not the communities are in fact similar on any basis on which he might make such a statement.

In other words, we don't intend to rely on a difference in specific techniques as was stated in the Little case.

THE COURT: All right. Anything else, Counsel?

MR. CANTOR: If Your Honor please, I will just state again that Dr. Kramer has stated that the teaching procedures are the same at Fairfax as at the Medical College of Virginia, the standard to which the metropolitan area pediatricians are held to, sir, and he has stated his familiarity with that. I submit to the Court that he is fully qualified to go forward with his knowledge, sir.

THE COURT: What I was referring to was at Page 74 in 217 Va. when we get to the top of that page before you start the new paragraph, the last sentence, where it states, "This witness also expressed the opinion that a physician could not

(tr 49) * * *

learn the medical standards of other areas merely by attending medical meetings." In other words, I don't want to defer the ruling and then go to the defendants' evidence and then have to cover that and then come back to taking the plaintiff's evidence later on or to let you put a witness on now.

Are there any of your witnesses, including your defendants, who take the position that you do not learn medical standards of other areas merely by attending medical meetings? In other words, do you expect to have evidence on that either through your defendants or other witnesses? In other words, I don't want to spend two or three days going all the way through all of this sort of thing and having this matter under advisement and not allow this witness to testify to it if you are going to vouch the record as an officer of the court that either of your defendants and/or other witnesses would say that you don't learn medical standards by attending medical meetings in one area?

MR. SCOTT: Well, Judge, that question has not been approached to any of my witnesses.

THE COURT: Well, you have got two of them sitting right beside you.

MR. SCOTT: Well, I haven't asked them.

(tr 50) * * *

THE COURT: Well, then take the opportunity to ask them. I am not saying that you have to respond before you can ask them. You can talk to them, they are your clients, sit down and whisper to them.

You see what I am trying to get at? I don't want to get us all fouled up on one mere technicality which was alluded to in Little vs. Cross 217 Va. saying that the witness expressed the opinion that a physician could not learn medical standards of other areas merely by attending medical meetings.

MR. SCOTT: Unfortunately this witness has said that he can, and if he says he can then I guess that's a question for the weight of his testimony, if the Court feels that his testimony is sufficient.

THE COURT: Well, I don't think it's that material.

MR. SCOTT: I will be glad to talk to them about it, Judge.

THE COURT: Well, suppose the objection is overruled, suppose he goes ahead and testifies. Then, it would be perfectly logical for the Court to expect and the defendants to plan that the

(tr 51) * * *

doctors as well as other witnesses would say that you can't go to general medical meetings, not even specifying where, and learn what the particular practice is in a particular area. In other words, why in heaven's name do we have a Richmond Academy of Medicine? Why is Richmond a medical center when you are going to get some bush doctor from out in Botetourt County and bring him up here and have him say that he knows all the standards in this area when we have got a fine medical profession and fine medical academy setting standards. It's perfectly obvious that you could have a higher standard of medical care and skill in a medical center than you can out in Oshkosh, that's what I am really saying.

MR. SCOTT: I think that's what the Court of Appeals is saying, that you have to establish some basis for a familiarity with the locality rule, and if the man says that he can go to a meeting and read a medical journal and say that he is familiar with the standard, then I guess we are stuck with it. But, what I am saying--

THE COURT: You are saying he can't do that?

MR. SCOTT: What I am saying to the Court is that even if he says it does, it doesn't necessarily establish that familiarity under these

(tr 52) * * *

opinions. I think the final paragraph that Mr. Cantor alluded to is significant, and you will notice--

THE COURT: Where are you now?

MR. SCOTT: I am still on Page 74.

THE COURT: All right.

MR. SCOTT: They differentiate between the witness saying that he was familiar and his testimony not showing as a fact that he was familiar. I think that's one of the bases on which the Court made its ruling, that as a matter of fact his testimony did not disclose that he was familiar even though he said that he was or attempted to say that he was. As a matter of fact, we may well raise the question as a matter of testing credibility from other witnesses as to whether or not you can establish the standard by going to meetings and reading a journal.

I think we are bound with what he says, and our point is that what he says is not sufficient to raise it to the standards as required.

THE COURT: Anything else?

MR. CANTOR: Yes, sir. If Your Honor please, I think the Court should take into consideration Dr. Kramer's testimony. Not only does

(tr 53) * * *

he attend the meetings but he participates in them, and he teaches physicians from the Richmond area the standards of care of pediatric medicine, and that he is in discourse with these doctors of this area and it's not a question of simply reading and going to meetings.

This is someone who is an active practitioner in a skill which is taught as a basic skill to everyone who holds themselves out as being Board certified. This is not some exotic technique that one only learns in some place like Norfolk as even opposed to Richmond. This is a basic diagnostic tool, a basic diagnostic event that every pediatrician who seeks to be Board certified, who holds himself out to be able to distinguish types of rashes, should be able to know. It's not a medical technique, it's not a new machine to be used, this is a basic tool, and that's what Dr. Kramer has testified to. He said that it's the same standard of care as observed in Fairfax where there is a teaching hospital, as there is a teaching hospital in Richmond, and we are not seeking to impose a high standard of care on Botetourt County as the Court has alluded to, but in a city where there is the highest type of medical care expected. He's not seeking to bring down or raise up anything, but

(tr 54) * * *

he said that he is familiar with the same type of care that is used in both places.

THE COURT: Does that complete your statements on the matter?

MR. SCOTT: I have nothing further, Your Honor.

MR. CANTOR: Yes, sir.

THE COURT: All right. Gentlemen, based on the ruling partially in Bly vs. Rhoads in 216 Va. 645, at Page 652 where there was reference to the fact that the doctor admitted he was unfamiliar with Prince William County and the Court ruled that the similar or local community standard had not been met and therefore the objec-

tion to his testimony was sustained; and referring of course to the even stronger case in Little vs. Cross 217 Va. 71, almost entirely on Page 74 and 75, it is pretty clear that we have got to have somebody that knows something about the standards as they exist in Henrico County or the City of Richmond.

Now, the question is to what extent does this particular witness know anything about it. We apply the law in those two cases to the situation at hand, and the Court is not left with any other logical conclusion except to sustain the objection (tr 55) * * * made by counsel for the defendant.

Now, one of the things that they refer to in Little vs. Cross is saying in effect that they don't think much of people going to medical meetings and trying to find the standard somewhere else. But, let's look a little more closely at this thing.

In the first place, we have a man up until July of '73--and we are only concerned primarily with July of '73 to May of '74--a witness who never even had been in Virginia, everything had been in Maryland or the Air Force, or Washington, D. C., or something of that sort. He doesn't even get down into Virginia until July of '73.

MR. CANTOR: If Your Honor please, there was testimony that he was familiar with Virginia from '69 to '73, sir, that was his testimony.

THE COURT: Don't interrupt me, please, sir, I have already heard all your arguments.

MR. CANTOR: All right, sir.

THE COURT: Consequently you have a situation where in roughly a period of nine or ten months you would have this man become an authority and qualified to talk about all the standards in the area. Now, let's go back to what the nature of his basic employment is at the Fairfax Hospital.

(tr 56) * * *

His basic employment is only to teach, and he's teaching a field in pediatrics that relates to newborn children up to six months. Where does he claim he gets familiarity? He says he reads medical journals of the Medical Society of Virginia. He says that he attends some meetings.

Now, when you get down more specifically in the cross-examination he doesn't remember a single specific article or topic or anything relating to a diagnosis of any sort relative to Rocky Mountain spotted fever. He has never had a specific treatment of that type of case that he knows about in Virginia, except for some vague reference to some case someplace else. He doesn't recall any specific program of any medical society meetings he went to, and he only went to several meetings, relating to this disease. He has never treated anyone at all for Rocky Mountain spotted fever.

He also indicated that certain other literature he read didn't relate at all to anything in the standards of the State of Virginia. His contact with any physicians in the State of Virginia

is, to sum it up, purely at best a mere sort of an exposure. There is nothing to indicate that he ever specifically discussed anything with any doctor,

(tr 57) * * *

including Dr. Draper of MCV who he said he knew. He couldn't recall the name of some fellow in Norfolk, and he recalled the name of a doctor in Newport News. But, he never indicated that he had any specific discussions with either of them relating to what the specific standards are. He mentioned that he had no discussion with any of the physicians that he knows relative to Rocky Mountain spotted fever or the standards in connection with the treatment for Rocky Mountain spotted fever.

Now, somewhere along the line he indicated in his testimony, I forget the precise place, that he was reading literature that had sort of a national application and that's why he considered himself knowledgeable. Well, the national standard of course has never been applied in Virginia and in one of the two cases Justice Carrico was stating that it does not apply, we are confined to the local standard.

Now, based on this the Court takes the view that you just can't have someone testify who is not qualified by his own admissions of knowing what the local standards are in the field in which we are dealing with, pediatricians, doctors dealing with people of the age that this particular boy was,

(tr 58) * * *

age 11. The most this man has said in any event is that he knows something about pediatrician work from newborn children up to six months of age, and anything else after that is pure casual reference without any specifics.

I see no basis under the Virginia decisions of what they expect in these cases to permit this witness to give any opinion with respect to the situation.

Now, what is the pleasure of counsel at this point?

MR. CANTOR: If Your Honor please, counsel for the plaintiff of course objects and excepts to Your Honor's ruling. If Your Honor wants us to put Dr. Kramer's testimony in the record we can do so, or we can wait until tomorrow morning for our other physician to be here, sir.

THE COURT: Don't put me on terms, I don't want you to do that. It's up to counsel to decide what you do, that's why I asked you what you wanted to do next.

MR. CANTOR: Well, I would prefer, if Your Honor please, to wait until tomorrow morning and let Your Honor rule on the physician we will have then.

THE COURT: All right, then whose testimony

(tr 59) * * *

do you wish to go forward with now?

MR. CANTOR: Well, first, if Your Honor please, we would like to complete Dr. Kramer. Perhaps we should complete his testimony in the absence of the jury so the record will be complete in that respect.

THE COURT: Well, that's perfectly permissible, that's why I asked what you intended to do.

MR. CANTOR: All right, I will call Dr. Kramer back to the stand.

THE COURT: All right, continue with your examination.

REDIRECT EXAMINATION

BY MR. CANTOR:

Q. Dr. Kramer, when a patient presents himself with a rash and a fever, what does the standard of care in Henrico County that you are familiar with, require for a pediatrician to do as far as diagnosis and treatment?

A. The physician will first assess the detailed history from the patient or the person representing him. He will then conduct a complete examination of the patient and will assess the degree of severity of the illness and then decide whether there is any need for laboratory tests to support his clinical findings. Depending upon what he finds,

(tr 60) * * *

he will determine whether there is the potential for a viral illness, or rickettsial illness, or bacterial illness.

Q. Earlier this morning we had some discussions about Rocky Mountain spotted fever. I ask you to describe that illness to us and what causes it.

A. It's a rickettsial disease which is obtained by contact with a tick, which will usually be in the scalp of the individual

for several hours. The tick will imbed itself in the skin of the affected person and transmit the rickettsial germ to the individual which will then have an incubation period of anywhere from four to eight days, and it may last a little longer, maybe up to ten days, two weeks on occasion.

Then the child will have symptoms of fever, malaise, soreness of the body, central nervous system manifestations, and will develop a rash usually by Day 3 to Day 5 starting in the distal portions of the body, the hands and feet, and working its way centrally. This rash may take on different characteristics which are sometimes difficult to differentiate as being rickettsial, but will evolve into a hemorrhagic rash normally at the end of the first week or the beginning of the second week, which is more classical of the rickettsial type of illness.

Q. What is the standard treatment for Rocky Mountain spotted fever?

A. When there is a history of a tick bite, or

(tr 61) * * *

recent exposure to a tick bite, or evidence of a tick being present in the afflicted person, and the subsequent fever that would be developed, that in itself would make you highly suspicious of Rocky Mountain spotted fever. The general recommendation at that point is an institution of antibiotic therapy in the form of chloramphenicol or tetracyclines to alleviate the illness.

Q. What is the usual result of this treatment?

A. The treatment generally has a favorable outcome if caught early enough in the course of the illness.

Q. What is the usual outcome of Rocky Mountain spotted fever which is untreated?

A. The mortality is quoted as anywhere from 20 to 40 percent of afflicted persons.

THE COURT: What was the percentage?

THE WITNESS: 20 to 40 percent mortality untreated.

Q. Would you describe the disease of measles and its causes, please.

A. Measles is a viral illness which is a respiratory-acquired illness. It's seen in children generally in the winter and early spring months. Commonly it may be an isolated finding or an outbreak within a childhood population. Its initial findings are respiratory in the sense that you will have the four common preliminary findings of: Koplik's

(tr 62) * * *

spots, which is the rash inside the cheek of the mouth; conjunctivitis, which is the redness of the mucous membranes of the eye; coryza, which is a cold-like manifestation of the nose; and cough, which is usually a very repetitious type of hacking cough that the child has. It is associated with fever and a rash usually seen by Day 3 which starts usually in the head, face, upper trunk area, and spreads distally towards the extremities. The fever is usually gone by Day 5, and the rash will diminish in characteristics usually

at the end of the first week.

Q. Doctor, I am going to present you with a hypothetical question, and given the following facts ask you can you within a reasonable medical certainty make a diagnosis of this child or person's condition. Assuming no previous serious illness, questionable whether measle vaccine has been received, a nodule on the left side of the head beneath the ear, and this pertains to an 11-year-old, white male child, temperature of approximately 101°, recent history of a tick bite, muscular aches, rash on body including palms of hands, absence of coryza, which is runny nose, absence of cough, absence of conjunctivitis, and absence of Koplik's spots. Can you give us your opinion as to this child's condition and a specific or differential diagnosis?

A. I would think you still have to work within a differential diagnosis at this point, including Rocky

(tr 63) * * *

Mountain spotted fever, and other potential infectious agents to be differentiated along with it; measles may be in there as an outside possibility, other infectious diseases like enterovirus, perhaps some bacterial infections earlier in their phase might be still considered, but the primary or paramount infectious agent that I would consider with that kind of history would be Rocky Mountain spotted fever.

Q. If I gave you the identical hypothetical question and omitted the question of the history of a tick bite, what would your opinion be as to the child's condition in a specific or

differential diagnosis?

A. When you remove the history of a tick bite your differential would broaden moreso because you would not then have the primary thing in the history which is important to know early on. When you don't have the history of a tick bite then you have a much broader sequence to go through.

Q. Would you tell us what your differential would include in that instance.

A. You would have to think of the common viral entities which can cause febrile illnesses: node enlargement, fever, malaise, that sort of thing. Rickettsial would be in there but probably lower down on your list. Bacterial infections such as scarlet fever, typhoid fever, other things of that sort would have to be included also.

Q. In your opinion does the failure to make a

(tr 64) * * *

differential diagnosis which includes Rocky Mountain spotted fever under the above questions breach the standard of care owed to a patient by a physician practicing pediatric medicine in the metropolitan area of Richmond in 1974?

A. Yes.

Q. In your opinion, had the physician on May 22nd made a timely differential diagnosis which included Rocky Mountain spotted fever, and instituted proper treatment, with a reasonable medical propriety would the child have survived the onslaught of Rocky Mountain spotted fever?

A. Yes, with reasonable medical considerations.

Q. Is it your opinion that on May 25th, assuming that the child was first seen on May 20th and again on May 22nd, but on May 25th had a physician made a timely differential diagnosis, with the above symptoms, that included Rocky Mountain spotted fever and instituted proper treatment for it, with reasonable medical propriety would the child have survived the onslaught of Rocky Mountain spotted fever?

A. Its chances would have been better, yes.

Q. In the differential diagnosis, do you treat for the less serious disease or the more serious disease, or how do you go about knowing which one to treat when you have a differential diagnosis to work with?

A. You have to weigh the manifestations of

(tr 65) * * *

the child and how he presents. If he doesn't appear very ill, you are following the child very closely and you have ongoing contact with the child and the mother, you may elect to watch the child carefully over the course of several days to be sure which way he is going, or the outcome of the illness. If things are obviously not going right and this child is either persisting with the symptoms or they are progressing then you have to weigh whether your more serious illnesses are now becoming of concern, and they are now the ones that necessitate the use of antibiotic therapy. So, I think it's a matter of weighing the course of the

illness as you are following it as well as the child's course.

MR. CANTOR: I have no further questions, Dr. Kramer.

THE COURT: Do you wish to cross-examine?

MR. SCOTT: Yes, just one or two questions, Your Honor.

RECROSS-EXAMINATION

BY MR. SCOTT:

Q. Dr. Kramer, let me ask you another hypothetical question. Suppose you have an 11-year-old child who comes to your office and his mother reports that he's had a temperature of 101 or 102° which has been reasonably controlled by aspirin, that he's got some pain in the left side

(tr 66) * * *

of his neck and a swollen lymph gland in the left side of his neck, that you take his temperature and he's got a temperature of 100 with a history of taking aspirin several hours previously, that you examine him and find a left posterior lymph node is slightly swollen, that your ear, nose and throat examination is negative, that your heart examination is negative, that your abdominal examination reveals no masses, that the lungs are clear, and in addition that you have a history of a tick bite at that time. Two days later the patient returns with a small, red, slightly raised rash over the entire body with no history of any starting on the extremities and moving up, that the patient has a white coated tongue, that he has a history of nausea and vomiting for the past day or so, that he has stomach pain, that his oral temperature is 99.4 with the taking of aspirin within a couple of hours

prior to the time of the appointment, that the physical examination is otherwise within normal limits, would it be your opinion that the standard of practice at that time would be to institute antibiotic therapy for Rocky Mountain spotted fever?

A. With the history of the tick bite and the presence of associated node, with the presence of an ongoing febrile illness over the course of several days, and rash which has now appeared, that would have to be high on my list or the top of my list as far as Rocky Mountain spotted fever

(tr 67) * * *

goes. And, yes, antibiotic therapy at that point would be indicated.

Q. You would start it at that time?

A. Yes.

Q. Suppose you removed the history of a tick bite?

A. If you remove the history of a tick bite then your differential has to widen.

Q. Well, I'm asking you about treatment.

A. Treatment at this point, it depends upon how the child looks. If he doesn't look toxic, and you are suggesting that he is not toxic at this point, at this point then close observation may be warranted provided no laboratory tests are indicated and you would see the child at regular intervals to guarantee he's not deteriorating.

Q. Does the physician's judgment as to whether or not the patient is toxic have an effect or should it have an effect on his judgment as to whether or not to institute treatment even with the presence of a history of a tick bite?

A. Say that again, I am sorry.

Q. Assuming the tick bite and all other facts, should the physician's judgment as to whether or not the patient appears toxic have an effect on whether or not he institutes treatment at that time?

A. No, you have a tick bite and fever and that

(tr 68) * * *

in itself would be enough indication for treatment.

Q. How about a tick bite and a rash with the exclusion of all other symptoms, would you institute treatment in that case?

A. Without fever, no.

Q. How about tick bites, rash, and fever of 99.4°?

A. A fever at one particular moment doesn't give you the clinical course because that could have been modified by aspirin or Tylenol, and you would have to know what the child was doing without those drugs on board. You would have to treat him if the fever was higher than that at other times.

Q. How about a history without any evidence of a tick bite, without any evidence that he's been bitten, just the fact that he has a tick on him?

A. The presence of a tick if it's removed early on does not convey Rocky Mountain spotted fever necessarily, and watching the child closely in a close clinical fashion is all that is necessary at that point.

Q. You have to have actual evidence of a bite before you would institute therapy immediately?

A. No.

Q. That's not true?

A. No. The history of a tick bite makes the

(tr 69) * * *

sequence flow much easier. If you don't have the history of a tick bite or any clinical evidence that you can suspect that there has been a tick bite then your clinical judgment becomes much more difficult, and then what happens in the course of the illness, your evaluation of how the rash is progressing, how the febrile course is going, it all has to be weighed into your differential and your decision for treatment.

Q. One more question, Dr. Kramer. Could you tell the Court, and for the record, how you became involved in testifying in this case?

A. I am an independent physician who works as a consultant for the Medical-Legal Consultants League.

Q. Is that Dr. Jacobs' outfit?

A. No, it is not.

Q. Who runs that?

A. Mr. Militano.

Q. The attorney sitting in the courtroom?

A. Yes.

Q. And he receives cases and asks or send them to consultants to review?

A. Correct, and we will either review physician or defendant cases for merit, it doesn't matter which one is involved.

Q. You are on a salary with that organization?

(tr 70) * * *

A. No, I am not.

Q. Was that organization solely established and does it solely exist in the business of reviewing medical-legal issues in cases, or do you know?

A. I am not 100 percent sure. My feeling is that it is, but I would not want to speak for them.

Q. And you receive a fee from that organization to review records and render an opinion?

A. Correct.

* * *

(tr 71) * * *

* * *

FURTHER REDIRECT EXAMINATION

BY MR. CANTOR:

Q. Dr. Kramer, in answer to some of Mr. Scott's questions you stated "to watch the child closely." Can you tell us what you meant by that?

(tr 72) * * *

A. Well, in the course of any febrile illness in which you either have a presumptive diagnosis or you are working on a differential diagnosis you should have continuing contact with the patient until the course runs its sequence or until you are assured of the fact that the sequence is going astray either with a complication or to the point where you have decided maybe you are on the wrong track and maybe you need to reconsider what the differential should be because things are not following a set pattern.

Q. Does that mean hourly watch, daily watch, or what type?

A. It depends upon how things are going. If it's a relatively slow process then a daily watch might be quite adequate. If it's a more rapid sequence then hospitalization is required and more diligent observation.

Q. I understood you to say that with reasonable medical propriety this child would have survived if he had received the treatment for Rocky Mountain spotted fever?

A. Yes.

* * *

(tr 77) * * *

* * *

MARGARET A. NOLL, the plaintiff herein, called in her own behalf, first being duly sworn, testifies and states:

DIRECT EXAMINATION

BY MR. CANTOR:

Q. Please state your name to the members of the jury.

A. Margaret Ann Noll.

Q. How old are you, Mrs. Noll?

A. Thirty-eight.

(tr 78) * * *

* * *

Q. Can you tell us how many children you have?

A. I have four now.

Q. You had five counting David?

A. Yes.

* * *

(tr 80) * * *

* * *

Q. Going back now to May of 1974, specifically

(tr 81) * * *

the morning of May 20th, can you tell us about your son, David, his physical condition.

A. Yes. He woke up and told me that his neck hurt and that he had a pain behind his ear. When I checked his ear I noticed that his gland behind his ear was swollen. So, I decided that it would be the best thing to call a doctor because I am afraid of a mastoid which I do believe comes from behind the ear.

Q. Did you call the doctor?

A. Yes, I did.

Q. What doctor did you call?

A. I called the offices of Dr. Rahal and Dr. Jaffe.

Q. Were you given an appointment at that time?

A. Yes, I was told to bring him on in, I think it was around 10:00 o'clock in the morning.

Q. When did you bring him in?

A. I brought him on into the office around 10:00 o'clock.

Q. What transpired at the office when you arrived?

A. Well, I waited my turn to be called into the office and then was led back to the back room. David was undressed and his history taken, temperature, and a urinalysis was taken. Then I waited for Dr. Jaffe or Dr. Rahal to come in.

(tr 82) * * *

* * *

Q. Which doctor came to visit with you, or to examine David?

A. Dr. Jaffe.

Q. Can you tell us what he did and what he told you?

A. Well, he examined David in his throat and in his ears, behind his neck, and checked his heart, and told me that he thought David had a virus or some type of infected gland.

After David was dressed I remembered that David had complained of his head being sore on the way to the doctors' office, so I asked him to check in his head and see if there was anything that was causing it to be sore.

Q. David was dressed at that time?

A. He was dressed at that time.

Q. Was anyone else in the room with you then?

A. No, there was not.

Q. Did Dr. Jaffe examine his head?

A. Yes, he looked in his head and asked David which side of his head was it, and David pointed to this side. He looked in his head and told me that there was a tick bite there, and I asked him if the tick was still in it

(tr 83) * * *

and he said it wasn't, it was just a bite and that I could come and look. I got up from my chair and went across the room and saw the tick bite.

Q. Did he change his diagnosis or tell you any other medication after he saw the bite?

A. No, he did not, he just told me to give him Tylenol.

Q. Did you give David the Tylenol?

A. Yes. I stopped at the drugstore on the way home and bought the Tylenol and started David on it immediately.

Q. Now, this was on a Monday, was it not?

A. Right.

Q. Did he go to school the next day, which was Tuesday, May 21st?

A. No, he didn't.

* * *

Q. When was the next time you called the

(tr 84) * * *

offices of Dr. Rahal and Dr. Jaffe?

A. It was Wednesday the 22nd.

Q. What transpired on that day?

A. Well, I called the office and told the doctor that David had developed a rash that morning and that I didn't know what it was. I was afraid that it was something contagious, and I asked him if I could bring David in at the latter part of the visiting hours so as not to infect any other children that might be at the office at the time. So, he told me to bring David in around 2:00 o'clock, which I did.

* * *

Q. What transpired when you went there?

A. Well, I was ushered into a room opposite the one that I had been into previously. I don't remember whether Dr. Rahal completely took David's shirt off or

(tr 85) * * *

whether he just opened his shirt.

Q. Is this Dr. Jaffe or Dr. Rahal?

A. I meant Dr. Jaffe, excuse me. He checked the spots and checked his stomach because David at this time was complaining of pains and aches, muscle aches and stomach ache, and he checked him and asked me if he had had his shot for the measles. I told him that I did not remember, that he had had all of his baby shots, but they do have a shot program in the Henrico County schools

and he got all of those shots whenever they were made available. But, I wasn't positive if he had had the measles shots.

* * *

Q. What did Dr. Jaffe tell you David's difficulty was at this time?

A. He said it looked to him like the measles, and he kept repeatedly asking me if he had had the shot, but I couldn't tell him anything else than I had the first time,

(tr 86) * * *

that I thought he had but I could not be positive. He told me it looked like it was the measles.

Q. Did he give you some medication for that?

A. No, he did not. He told me to continue with the Tylenol.

Q. Did he make another appointment for you to see him?

A. No, he didn't.

Q. Did he tell you to come back to see him?

A. No, sir.

* * *

Q. What was David's course the next day, which was Thursday, May 23rd?

A. He was really vomiting, he couldn't keep anything on his stomach, he still had the aches, the rash was still present, and he was generally restless. I did give him Emetrol along with the Tylenol to try to control the vomiting, and I kept him on this all day.

Q. Emetrol?

A. Emetrol.

Q. Was that prescribed by Dr. Jaffe?

A. No, it wasn't.

Q. Where did you get it from?

(tr 87) * * *

A. I went to the drugstore and asked the druggist what was good for vomiting.

Q. What was his condition on Friday?

A. Generally the same.

Q. When did you next call the offices of Dr. Jaffe and Dr. Rahal?

A. Saturday morning.

Q. Who did you talk to then?

A. I think it was the answering service, and then Dr. Rahal called me back.

Q. What was David's condition at that time?

A. He was really getting worse. He was vomiting frequently, he couldn't keep anything on his stomach, and even the Emetrol I was giving him was coming back. I told Dr. Rahal that Dr. Jaffe had been seeing him and had said that he did have the measles, he thought he had the measles, and I asked Dr. Rahal what should I do. Subsequently he called in a prescription to the Standard Drug store, that was sometime Saturday afternoon, and I went to pick up

the prescription Saturday evening and gave it to David Saturday night.

Q. What was that supposed to do? Did he tell you what that would do for him?

A. That was supposed to reduce the vomiting.

Q. Did he tell you that he still considered

(tr 88) * * *

David to have measles, or what was said to you about that?

A. There was no further reference to the measles. He asked me what had Dr. Jaffe been treating him for and I told him the measles.

Q. That's on Saturday afternoon?

A. Yes, it was, late Saturday, around lunch-time.

Q. When was your next contact with the office?

A. Sunday morning.

Q. What was it about David's condition that prompted you to call the office?

A. He was considerably worse, he was staggering and was complaining of terrible muscle aches, and his fever had gone up again. So, I called the office on the chance that I might get Dr. Rahal in the office, and he told me that I ought to go ahead and bring David into the office at 2:00 o'clock.

Q. Describe to us what occurred when you went there then.

A. When I took David out of the car he couldn't stand for anybody to even touch him, his muscles were so sore. I tried to help him out of the car but when I did he screamed and said,

"Momma, don't do that." Then he collapsed and went into convulsions. Dr. Rahal helped me with him into the office and told me that it looked like measles on the brain.

(tr 91) * * *

* * *

Q. Did you discuss with Dr. Rahal the tick bite that had been seen on David on Monday?

A. Yes, I did.

Q. You discussed that with Dr. Rahal at that time?

A. Yes, I did, that evening.

THE COURT: What date are you referring to?

THE WITNESS: Sunday.

Q. May the 26th?

A. May the 26th.

Q. Did anyone at that time tell you anything about Rocky Mountain spotted fever?

A. There was no mention of Rocky Mountain spotted fever at that time.

Q. When did you first learn of that?

A. I learned of the possibility of Rocky Mountain spotted fever that evening, and an alternate diagnosis of spinal meningitis. Dr. Rahal said they were both primarily treated with the same medicine and that they did act something alike and that he wasn't sure which one it was.

Q. Dr. Rahal told you that?

A. That was late that evening.

* * *

(tr 93) * * *

* * *

Q. When did David pass on? When did he meet his death?

A. It was 12:30 Monday evening, Tuesday morning.

Q. At the Medical College?

A. Yes, sir.

* * *

(tr 125) * * *

* * *

THE COURT: So, he was 11 years old at the time?

THE WITNESS: Yes, sir.

* * *

(tr 155) * * *

* * *

MR. CANTOR: All right, sir, the plaintiff will rest her case, sir.

THE COURT: The plaintiff rests the entire?

MR. CANTOR: Yes, sir.

THE COURT: All right. Do I hear a motion?

MR. SCOTT: Yes. We, on the basis of counsel for the plaintiff's representation that the evidence at this time has been con-

cluded, would move the Court to strike the plaintiff's evidence and to enter summary judgment on behalf of the defendants on the grounds that under the applicable authorities in the State of Virginia, specifically the cases of Bly vs. Rhoads and Little vs. Cross, and cases cited in those cases and heretofore ruled upon by the Supreme Court, that there has been no evidence by competent medical testimony that the defendants, or either of them, have failed to conform to the standard of practice of pediatrics in the City of Richmond or Henrico County in May of 1974.

To the contrary, consistent with the Court's ruling yesterday, there has been no medical testimony whatsoever as to what happened. The sole testimony for the plaintiff at this time consists of the testimony of Mrs. Noll herself who obviously cannot (tr 156) * * *

and did not attempt to establish any standards of practice. There can be no evidence upon which the jury could conclude without pure speculation and surmise as to whether or not either of the defendants were guilty of any violation of the standard of practice in the diagnosis and/or treatment of the decedent in this case.

Furthermore, that even if there were such evidence there certainly could be no evidence that concludes that any definite actions on the part of the defendants would have been the proximate cause of death.

So, on that basis we would move to strike the plaintiff's evidence and request the Court to enter a summary judgment on behalf of the defendants.

THE COURT: All right. Is there anything you wish to say in reply?

MR. CANTOR: If Your Honor please, counsel for the plaintiff would just reassert the motion previously made, sir, because that's the basis of our testimony and without that we are unable to proceed further, sir.

THE COURT: All right, sir.

MR. CANTOR: We have a motion to make, sir, if Your Honor sustains that motion.

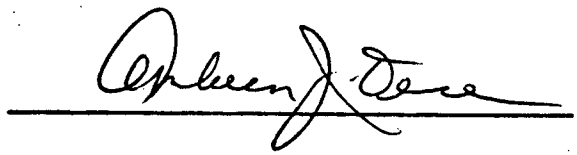
(tr 157) * * *

THE COURT: All right. The Court now sustains the motion of the defendant to strike the evidence and therefore enters summary judgment for the defendant pursuant to the Rules and for the reason stated by counsel for the defendant and for the cases relied upon by counsel for the defendant.

MR. CANTOR: If Your Honor please, as I understand it the Court has stricken the evidence, and of course we move that the Court set aside such verdict and move for a new trial, sir, being that the rulings of this Court in this matter are contrary to the law and evidence.

THE COURT: The motion is refused and denied. * * *

* * *

CERTIFICATE

I hereby certify that I have complied with Rule 5:49 of this Court by mailing three (3) copies of the Appendix on or before the day on which it is filed to R. Carter Scott, III, Esquire, Browder, Russell, Little, Morris & Butcher, 1200 Ross Building, Richmond, Virginia, 23219, Counsel for Appellees.