

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

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4 IN THE COURT OF COMMON PLEAS

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6 Iwona Valdivieso, etc.,)
7 Plaintiff,) Case No. 443978
8 vs.) Judge Mannen
9 University Hospitals of)
10 Cleveland, et al.,)
11 Defendants.)

12 - - -

13 DEPOSITION OF TIMOTHY J. KINSELLA, M.D.

14 WEDNESDAY, MAY 1, 2002

15 - - -

16 The deposition of Timothy J. Kinsella, M.D., called by
17 the Plaintiff for examination under the Ohio Rules of
18 Civil Procedure, taken before me, Ivy J. Gantverg,
19 Registered Professional Reporter and Notary Public in and
20 for the State of Ohio, by agreement of counsel and
21 without further notice or other legal formalities, at the
22 offices of Reminger & Reminger, 113 St. Clair Building,
23 Cleveland, Ohio, commencing at 9:12 a.m., on the day and
24 date above set forth.

25

1 APPEARANCES:

2 On Behalf of the Plaintiff:

3 Ronald A. Margolis, Esq.
4 Daniel M. Finelli, Esq.
5 Finelli & Margolis
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Cleveland, Ohio 44114

6 On Behalf of Defendant University Hospitals of Cleveland:

7 Kevin M. Norchi, Esq.
8 Moscarino & Treu
630 Hanna Building
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9 On Behalf of Defendant Dr. Shina:

10 Timothy G. Sweeney, Esq.
11 Bonezzi, Switzer, Murphy & Polito
12 1400 Leader Building
Cleveland, Ohio 44114

13 On Behalf of Defendants Case Western Reserve University,
14 Dr. Barry Wessels and Dr. Sam Beddar:

15 Stephen D. Walters, Esq.
16 Weston, Hurd, Fallon, Paisley & Howley
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Cleveland, Ohio 44113

17 On Behalf of Defendants Dr. Wiersma and Dr. Kinsella:

18 Marc W. Groedel, Esq.
19 David H. Krause, Esq.
Reminger & Reminger
113 St. Clair Building
20 Cleveland, Ohio 44114

21 On Behalf of Dr. Wiersma and Dr. Kinsella Personally:

22 Matthew P. Moriarty, Esq.
23 Brzytwa, Quick & McCrystal
1660 West 2nd Street - Suite 900
24 Cleveland, Ohio 44113

25 Also Present:

Susan Wiersma, M.D.
Barry Hersch, Videographer

1
2 (Thereupon, Kinsella Exhibits A (1-19)
3 and B (1-87) were previously marked for
4 identification.)

5 (Thereupon, Plaintiff's Exhibit 100 was
6 marked for identification.)

7 TIMOTHY J. KINSELLA, M.D.
8 a defendant herein, called by the plaintiff for
9 examination under the Rules, having been first duly
10 sworn, as hereinafter certified, was deposed and said as
11 follows:

12 MR. MARGOLIS: Would counsel just please
13 identify themselves for the record, and who they
14 represent?

15 MR. GROEDEL: My name is Marc Groedel, I
16 represent Dr. Kinsella and Dr. Wiersma.

17 MR. NORCHI: My name is Kevin Norchi, I
18 represent University Hospitals of Cleveland.

19 MR. WALTERS: My name is Stephen Walters, I
20 represent Case Western Reserve University,
21 Dr. Barry Wessels and Dr. Sam Beddar.

22 MR. SWEENEY: My name is Tim Sweeney, I
23 represent Dr. Shina.

24 MR. KRAUSE: David Krause, I represent
25 Dr. Kinsella and Dr. Wiersma.

1 MR. MORIARTY: Matt Moriarty, personal
2 counsel to Drs. Kinsella and Wiersma.

3 MR. MARGOLIS: And I am Ron Margolis, the
4 gentleman to my left is Dan Finelli. Jointly, we
5 represent the plaintiffs.

6 CROSS EXAMINATION

7 BY MR. MARGOLIS:

8 Q. Doctor, have you ever had your deposition taken
9 before today?

10 A. No.

11 Q. This is the first time you have ever testified
12 under oath?

13 A. I have been an expert witness, which I would have
14 testified under oath, yes.

15 Q. Okay.

16 When you were an expert witness, did you ever give
17 a deposition where your opinions were inquired by the
18 counsel representing the adverse party?

19 A. I can't recall. It was back in the 1980s.

20 Q. Okay.

21 A. I think I was representing the physicians.

22 Q. All right.

23 How many times have you served in the capacity as
24 an expert witness in a medical malpractice case?

25 A. I think there are three or four.

1 Q. And on those three or four occasions, when did
2 they start? When was the first time you served as an
3 expert witness?

4 A. It may have been 1982 or 1983. And I left the
5 National Cancer Institute in 1987, I don't think I did
6 anything after that.

7 Q. All right, so from 1987 to present, to the best of
8 your knowledge, you have not served in the capacity of an
9 expert witness?

10 A. That is right, that is correct.

11 Q. Have there been any other circumstances where you
12 have given testimony under oath?

13 A. Not -- no, not that I can recall.

14 Q. All right.

15 Doctor, I have handed you what has been marked for
16 identification purposes as Plaintiff's Deposition Exhibit
17 100, which is your curriculum vitae. Is that a current
18 copy?

19 A. Yes, as of April of 2002.

20 Q. Thank you.

21 You were also asked to bring with you today some
22 other documents, specifically the original office file
23 including any and all correspondence which represent
24 plaintiffs in this case. Have you brought that with you
25 today?

1 A. No one made that request of me, I think.

2 MR. GROEDEL: Well, we have given you the
3 office chart. You have the original there. Dan
4 is looking at it right now.

5 MR. MARGOLIS: Okay.

6 Dan, can I have that for one second? Let
7 me just mark it.

8 Ivy, can I have an exhibit sticker. Just
9 mark it 101.

10 (Thereupon, Plaintiff's Exhibit 101 was
11 marked for identification.)

12 BY MR. MARGOLIS:

13 Q. Doctor, handing you what has been marked as
14 Plaintiff's Exhibit 101 --

15 A. Yes.

16 Q. -- would you please identify that for me?

17 A. It is the department of radiation oncology
18 treatment record for Joshua Valdivieso.

19 Q. And is that the original chart, sir?

20 A. Yes, it appears to be.

21 Q. All right.

22 Where would that chart be kept in the normal
23 routine course?

24 A. While Joshua was a patient, it would be kept in
25 the department of radiation oncology.

1 Q. All right.

2 Do you have any other records relative to Joshua
3 Valdivieso, other than what is set forth in Exhibit 101?

4 A. No, I do not.

5 MR. MARGOLIS: All right, can I have that,
6 Marc?

7 (Thereupon, the file was handed to
8 Mr. Margolis.)

9 BY MR. MARGOLIS:

10 Q. And Exhibit 101 would contain a complete and
11 accurate copy of all the records which would have been
12 generated by your department and yourself relative to
13 care of Joshua Valdivieso?

14 A. Yes.

15 Q. Have any records been removed from that chart?

16 A. No, they have not.

17 Q. I also asked you to bring with you today, sir, any
18 and all billings relative to the care and treatment
19 rendered to Joshua Valdivieso. Do you have that?

20 A. No, I do not.

21 MR. GROEDEL: We will provide you with
22 that. I did not ask Dr. Kinsella to provide that
23 information.

24 MR. MARGOLIS: Okay.

25

1 BY MR. MARGOLIS:

2 Q. I also asked you to bring with you today any and
3 all documents that you have prepared subsequent to your
4 receipt of the lawsuit in this matter, certainly not
5 documents to your lawyers.

6 Have there been any documents that you have
7 prepared after you received the initial lawsuit in this
8 matter?

9 A. No, there have not.

10 Q. So you would not have altered or changed any
11 documents in the medical record after you received the
12 lawsuit in this matter?

13 A. No, I did not.

14 Q. Did you review any hospital protocols, rules,
15 regulations, bylaws or guidelines after the lawsuit was
16 received by you in this matter?

17 A. No, I did not.

18 Q. In your position at University Hospital at the
19 time that you treated Joshua Valdivieso, were you aware
20 of the hospital protocols, rules, regulations and
21 guidelines that would govern a physician's treatment of a
22 patient?

23 A. I was aware of them.

24 Q. Are they in a written format somewhere, sir?

25 A. I am sure they are. I don't have them in my

1 office or I don't keep them.

2 Q. As the chairman of the department, though, would
3 you have some administrative responsibilities?

4 A. Yes, I do. And those records would probably be in
5 the administrator's office.

6 Q. I also asked you to bring certain documents which
7 were generated relative to an investigation that was
8 performed at the University of Wisconsin Medical School
9 Department of Human Oncology involving yourself during
10 the years 1996 and 1997. Do you have any documents in
11 your possession that were generated as a result of that
12 investigation?

13 A. No, I do not.

14 Q. Were you ever forwarded any letters or documents
15 by Phillip Farrell relative to that investigation or any
16 decisions made as a result of that investigation?

17 A. I may have received some, but I certainly didn't
18 save those. I can't recall specifically. I have no
19 records from there.

20 Q. What do you believe you would have received from
21 Phillip Farrell?

22 MR. GROEDEL: Objection.

23 You may answer, if you can.

24 A. He is or was the Dean of the medical school. I am
25 not sure what records he would have sent me. I don't

1 have those. I certainly didn't save anything from -- I
2 left there five years ago.

3 Q. What about Gordon Derzon?

4 A. He was the CEO of the hospital. Again, I have no
5 records.

6 Q. Were you provided any records by Gordon Derzon
7 that you have recollection of, whether you retained them
8 or not?

9 MR. GROEDEL: Objection.

10 You may answer.

11 A. I can't recall receiving any.

12 Q. What about David Ward?

13 A. He is -- he was the Chancellor of the university,
14 and again, I have no records, and I can't recall anything
15 specifically.

16 Q. Do you believe that you were forwarded any records
17 by David Ward relative to that investigation --

18 MR. GROEDEL: Object.

19 Q. -- and its conclusions?

20 MR. GROEDEL: Objection.

21 You may answer.

22 A. I can't recall.

23 Q. What about Dr. Scott Springman?

24 A. He is an anesthesiologist. I am not sure if he is
25 still there. Again, nothing that I have.

1 Q. What about documents from Lisa Brunette?

2 A. I don't know who Lisa Brunette is. Sorry.

3 Q. All right.

4 What about documents from UW Provost John Whiley?

5 A. Again, I don't have any recollection and I don't
6 have any records.

7 Q. What about documents from Casey Nagy?

8 A. I don't have any records or a recollection of
9 receiving anything.

10 Q. You will agree with me that an investigation was
11 commenced relative to your time at University of
12 Wisconsin Medical School involving yourself and medical
13 records and billing practices, correct?

14 MR. GROEDEL: Objection.

15 You may answer.

16 A. Correct.

17 Q. And you will agree with me that as a result of
18 that investigation, allegations were made that you saw
19 patients, charted clinical findings and diagnoses,
20 billed, but in fact did not examine the patients on the
21 indicated dates; are you aware that substantively those
22 were the allegations of that investigation?

23 MR. GROEDEL: Objection.

24 You may answer.

25 A. There were allegations of procedures occurring

1 called simulations where I wasn't present, and a bill was
2 sent, but it didn't require my presence, based on that
3 time frame.

4 Q. Why did --

5 A. There was a change in our physician or attending
6 to resident responsibilities.

7 Q. Is it your testimony here today that you did
8 nothing improper relative to the substantive matters
9 which were being investigated by the University of
10 Wisconsin?

11 A. Yes.

12 Q. Why did you voluntarily choose, then, to reimburse
13 them \$15,000 to help defray the costs of the
14 investigation?

15 MR. GROEDEL: Objection.

16 A. I actually can't recall the specifics of that.

17 Q. You have no recollection as to whether or not you
18 voluntarily paid money to the University of Wisconsin
19 Medical School to defray the costs of the investigation
20 that was conducted involving yourself?

21 MR. GROEDEL: Objection.

22 A. I can't recall the specifics.

23 Q. Did you issue them a check for \$15,000 at the
24 conclusion of the investigation?

25 MR. GROEDEL: Objection.

1 You may answer.

2 A. I can't recall.

3 Q. Did you reimburse \$5,815 for billings that were
4 made to patients that were determined to be inappropriate?

5 MR. GROEDEL: Objection.

6 A. I can't recall. They -- we had a practice plan
7 that may have done that. I don't think I personally did
8 that.

9 Q. What about the 15,000, was that from the practice
10 plan, as well?

11 A. I can't recall.

12 Q. You had counsel that represented your interests in
13 that matter, did you not?

14 A. Yes.

15 Q. And what was the name of counsel?

16 A. It was -- I am blocking on his name right now.

17 Q. Okay.

18 While you were at --

19 A. Michael Weiden.

20 Q. Tell me the position that you held, sir, at
21 University of Wisconsin Medical School?

22 A. I was chairman of the department of human oncology
23 and a professor, I had a named chair, and I can't -- it
24 is, I think, the Anderson chair.

25 Q. Were you involuntarily removed from the

1 chairmanship of that department?

2 MR. GROEDEL: Objection.

3 You may answer.

4 A. Each year we had a vote for the chairs at
5 Wisconsin, it is the faculty members. One year I did not
6 receive a majority of the votes.

7 Q. Were there allegations by your colleagues against
8 you that you were administering treatment that was
9 medically excessive and not warranted for billing
10 purposes?

11 MR. GROEDEL: Objection.

12 You know, I think, Ron, I have let you go,
13 you know, as far as I think you should go in this
14 matter, and I am going to instruct the witness not
15 to answer any further questions about what
16 happened back at the University of Wisconsin. You
17 know, I think you have gone far enough in that
18 regard. I don't think it is relevant, you have
19 withdrawn your discovery requests for that
20 information.

21 MR. MARGOLIS: Well, the discovery
22 requests, Marc, that were withdrawn, were
23 withdrawn at this point in time for our specific
24 strategy reasons in the case. That does not act
25 as a waiver, or preclude me. There are still

1 pending claims that are directly relevant to that.

2 I would ask your indulgence, I have one or
3 two questions on this area, and then I am done.

4 MR. GROEDEL: Restate that -- repeat the
5 question.

6 MR. MARGOLIS: Fair enough.

7 Could you please read back the last
8 question.

9 (Record read.)

10 MR. GROEDEL: Objection.

11 If you know.

12 A. Allegations were made. Nothing was substantiated.

13 Q. All right.

14 And my last question on this issue -- and Marc, I
15 appreciate your allowing me to finish this area --
16 subsequent to this investigation that we discussed, did
17 you receive any disciplinary notification or action?

18 MR. GROEDEL: Objection.

19 A. No, I did not.

20 Q. You were also asked to bring with you today the
21 Record and Verify System and any and all documents that
22 would be produced relative to the total body irradiation
23 administered to Joshua on January 26th, 27th and 28th of
24 2000.

25 A. Those should be in the chart.

1 Q. Okay, could you point those out to me, please? We
2 will provide you with the chart.

3 And before you do that, please tell me what the
4 Record and Verify System is?

5 A. It is a backup system that allows the therapist to
6 enter a dose, and if it is a wrong dose, it would not
7 allow the machine to deliver the dose.

8 Q. Okay.

9 And would that have been a system that would have
10 been in effect in January of 2000 when Joshua was
11 receiving his TBI?

12 A. I can't recall when exactly we started the Record
13 and Verify.

14 Q. How would I determine that, sir?

15 A. You would have to -- you have to go back and ask
16 the physicist when that was installed.

17 Q. All right.

18 Was that a system that was utilized during your
19 time at Wisconsin?

20 A. I think it was. I think Record and Verify is a
21 Varian product.

22 Q. And Doctor --

23 A. We had some Varian equipment.

24 Q. I had asked you about this Record and Verify
25 System in the documents generated, and you had indicated

1 that it would be in the chart, and I forwarded you the
2 chart. Is it in there, sir?

3 A. I don't see it. I see the recording of the dose,
4 but they don't --

5 Q. And we will get to that.

6 Would -- is there a specific document which is
7 generated by the Record and Verify System?

8 A. I think there is.

9 Q. All right.

10 Would it normally be in your office chart?

11 A. That is a department chart, not my office chart.
12 But I assume it is.

13 Q. And when you have looked in it, you have not been
14 able to locate it in the departmental chart?

15 A. Just looking now, I can't see it. It should be
16 right in that treatment area, that summary.

17 Q. All right.

18 I know that there is a hospital chart on Joshua, I
19 know that there is a departmental chart.

20 A. Uh-huh.

21 Q. Is there any other chart? I used the word, office
22 chart. Is that part of your departmental chart?

23 A. That is the departmental chart.

24 Q. Okay.

25 Let me just quickly scan your CV.

1 Doctor, have you authored any articles on
2 neuroblastoma?

3 A. No, I have not.

4 Q. When did you meet Dr. Wiersma?

5 A. In 1990.

6 Q. And you were married?

7 A. In 1993.

8 Q. Have you and Dr. Wiersma always worked at the same
9 medical institutions?

10 A. Yes.

11 Q. And Dr. Wiersma is a Board certified pediatric
12 oncologist?

13 A. Correct.

14 Q. And you, sir, are a Board certified pediatric
15 oncologist, as well as a pediatric radiation oncologist;
16 is that correct?

17 A. No, I am not a Board certified pediatric
18 oncologist nor --

19 Q. Okay.

20 A. And there is no Board certification for pediatric
21 radiation oncologist. I am a Board certified internist,
22 Board certified adult medical oncologist and a Board
23 certified radiation oncologist.

24 Q. All right.

25 Does Dr. Wiersma regularly refer patients to you

1 for radiation oncology evaluation and treatment?

2 A. Yes.

3 Q. Has Dr. Wiersma regularly referred patients to
4 you, from '93 to present?

5 A. Yes.

6 Q. Approximately, can you tell me since the time that
7 Dr. Wiersma -- did she start at UH at the same time you
8 did, sir?

9 A. Started three years later. I started in '87 and
10 Susan started in '90.

11 Q. All right.

12 MR. NORCHI: University of Wisconsin?

13 THE WITNESS: Yes, University of Wisconsin.

14 Q. (Continuing) My question is, at University
15 Hospitals of Cleveland, when did you start?

16 A. I started in November of 1997 in an administrative
17 role. My Ohio license was not issued until February or
18 March of 1998, so that is when I would have started
19 practice.

20 Q. When did Dr. Wiersma start?

21 A. I think in July of 1998.

22 Q. Can you give me any kind of idea of how many
23 patients Dr. Wiersma would refer to you for evaluation
24 and treatment on a yearly basis?

25 A. Ten or 15.

1 Q. Would you ever discuss your evaluation of the
2 patients jointly with her?

3 A. Yes.

4 Q. All right.

5 I know there are consult notes that go back and
6 forth.

7 A. Right.

8 Q. But given the fact that you are married, would you
9 ever discuss what is going on with the patients outside
10 of a professional setting?

11 A. We try not to.

12 Q. Does it happen?

13 A. It happens.

14 Q. If there are cases that are out of the ordinary
15 for one reason or another, the two of you may discuss
16 that out of the hospital on your personal time?

17 A. Yes.

18 Q. All right.

19 Has your medical license ever been revoked,
20 suspended?

21 A. No.

22 Q. Has there ever been any disciplinary action taken
23 against your medical license?

24 A. No.

25 Q. In any state?

1 A. No.

2 Q. The expert work that you did, did it involve
3 issues of neuroblastoma?

4 A. Did not. No, it did not.

5 Q. Would you feel that Dr. Wiersma, based upon her
6 education, skill and experience, has more experience in
7 treating patients with neuroblastoma than you?

8 A. Yes.

9 Q. Would you defer to Dr. Wiersma on issues of
10 prognosis for this disease?

11 A. Possibly.

12 Q. What is the caveat? Usually when I say, defer to
13 my wife, I do it blankly. So what is the caveat here?

14 A. Well, again, I certainly know the disease process,
15 so I could render an opinion that could be different than
16 hers.

17 Q. Okay.

18 A. And certainly in other pediatric cancers that are
19 common cancers, I clearly have much more experience than
20 probably the majority of pediatric oncologists in the
21 world, such as Ewing's sarcoma.

22 Q. Doctor, what medical records have you reviewed in
23 preparation for this deposition?

24 A. I have reviewed the department of radiation
25 oncology records.

1 Q. Which would be Exhibit 101?

2 A. Right.

3 I reviewed the pediatric -- pediatric oncology
4 records. And this morning, for the first time, I saw the
5 hospital records.

6 MR. GROEDEL: Portions of them.

7 A. (Continuing) Yes, I saw the -- right, the note I
8 wrote on 1-26 I didn't know existed before.

9 Q. Doctor, what I have done to try to make it easier
10 for us is I have bound exhibits that I will be making
11 reference to during the course of this deposition, and at
12 this point, counsel, this will be given to the court
13 reporter.

14 I am asking you to look at the file marked
15 Dr. Kinsella A, and I would ask you to please turn to
16 Exhibit 19.

17 MR. WALTERS: What is this?

18 MR. MARGOLIS: This is the 5-31-2000
19 letter.

20 Do you have yours that you could like give
21 back to them, so that they can --

22 MR. FINELLI: Yes.

23 MR. MARGOLIS: 19, Steve.

24 MR. WALTERS: Thank you.

25 MR. MORIARTY: With all of its attachments?

1 MR. MARGOLIS: No, it is just the front
2 page of the letter.

3 BY MR. MARGOLIS:

4 Q. That is okay, if you could just look at it,
5 because it is marked, and I am going to give that to her.

6 Doctor, handing you Exhibit 19, please take your
7 time to review it.

8 A. (Witness complies). I have read it.

9 Q. Is that -- is this the first time that you have
10 seen that document?

11 A. No, Marc Groedel provided me with a copy of this
12 approximately a month ago.

13 Q. Prior to receiving the document sometime in March
14 of 2002, have you ever seen Exhibit 19 before that date?

15 A. No, I have not.

16 Q. Did you have any knowledge that Exhibit 19 existed
17 prior to March of 2002?

18 A. No, I did not.

19 Q. Were there any rumors or rumblings within the
20 department that you had knowledge of prior to March of
21 2002 on the issues set forth in Exhibit 19?

22 MR. GROEDEL: Objection.

23 You may answer.

24 A. I know of no rumors or rumbles, however you
25 phrased it.

1 Q. Do you know who authored Exhibit 19?

2 A. No, I do not.

3 Q. Doctor, do you remember when you were served with
4 the lawsuit in this case?

5 A. I can't actually recall the date.

6 Q. Do you remember the month?

7 A. It was July of last year.

8 Q. That is probably right. It was filed July 11th,
9 2001.

10 Who did you speak with after you received a copy
11 of the lawsuit, starting, if we can, first?

12 A. I actually didn't read it, I think, for up to a
13 month, I didn't. And I think I talked to my wife, Susan,
14 about it, since she was named.

15 Q. And you -- were you expecting to be sued in this
16 case?

17 A. No.

18 Q. And you saw that you were named as a party
19 defendant?

20 A. Right.

21 Q. And you did not read any portions of the lawsuit
22 for approximately a month after you received it?

23 A. I think so.

24 Q. All right.

25 Did you turn it over to someone to handle on your

1 behalf?

2 A. No, I did not.

3 Q. Okay, so it sat on your desk for about a month,
4 and then you decided it would be a good idea to review
5 it?

6 A. I think Susan actually also received a copy, and I
7 think she read it first.

8 Q. All right.

9 Did you speak with Dr. Shina about the lawsuit at
10 any point in time from when you received it until
11 present?

12 A. Once, about a month ago, after he was named.

13 Q. Tell me where that discussion occurred and what
14 was said?

15 A. It occurred, I think, in the clinic. He said he
16 was named along with Dr. Wessels and Dr. Beddar. And I
17 was surprised, I didn't know why he would be named. And
18 that was the conversation.

19 Q. Was anyone present when he had this discussion
20 with you?

21 A. I don't think so.

22 Q. Did he initiate it, or did you?

23 A. He did, because he had been named.

24 Q. And he simply said to you, I have been named in
25 this lawsuit along with these physicists?

1 A. Correct.

2 Q. And you said nothing?

3 A. Correct. I said -- well, I expressed surprise.

4 Q. Did Dr. Shina bring to your attention that Joshua
5 was administered 1 Gray during his TBI as opposed to 10
6 Grays?

7 A. No.

8 Q. Did anyone bring to your attention at any point in
9 time that Joshua was administered 1 Gray during his TBI
10 instead of 10?

11 A. Not that I recall, no.

12 Q. If that information had been brought to your
13 attention, i.e. that Joshua was administered 1 Gray
14 instead of 10, what action would you have taken?

15 A. Oh, I would have notified the physicians involved,
16 I think we would have notified the hospital, and they
17 would notify the -- obviously the patient and/or the
18 parents.

19 Q. So it is your testimony, Dr. Kinsella, that at no
20 point in time before this lawsuit being filed were you
21 ever advised by anybody that this patient had received 1
22 Gray of TBI instead of 10?

23 A. Yes, correct.

24 Q. Dr. Kodish, did you have any discussions with him
25 relative to the lawsuit?

- 1 A. No, I did not.
- 2 Q. Dr. Shurin?
- 3 A. I had a discussion with Dr. Shurin, I think in --
- 4 I would guess in September of 2001, or it could have been
- 5 October, that she brought it up that she was aware, and I
- 6 said I made a mistake in the prescription, and it was a
- 7 brief conversation. She related a time when she had made
- 8 a mistake in a prescription, and basically said, you
- 9 know, things like that can happen. It was a very brief
- 10 discussion.
- 11 Q. What about Barb Scott?
- 12 A. No.
- 13 Q. Sam Beddar?
- 14 A. No.
- 15 Q. Barbara Gleason?
- 16 A. No.
- 17 Q. Dr. Kitchen?
- 18 A. No.
- 19 Q. Dr. Wiersma?
- 20 A. Not -- I mean, obviously after the suit, we were
- 21 aware of it, I certainly talked to her about it.
- 22 Q. David Abrams [sic]?
- 23 A. No.
- 24 Q. Barry Wessels?
- 25 A. No.

1 Q. Diane Otto?

2 A. No.

3 Q. You told me that you started at UH in November of
4 '97 and you started your clinical work February of '98.
5 Give me --

6 A. Or March, I can't recall.

7 Go ahead.

8 Q. All right.

9 Give me an idea of what your duties and
10 responsibilities are at Case -- or at UH? You are the
11 chairman of the department?

12 A. Correct.

13 Q. And chairman of what, the department of radiation
14 oncology?

15 A. Radiation oncology, yes.

16 Q. All right.

17 And does that attendant responsibility have
18 certain administrative duties?

19 A. Yes.

20 Q. And how much of your time is involved in
21 administrative duties?

22 A. I probably spend 20 percent of my time in
23 administration.

24 Q. And what do the administrative duties involve?

25 A. I am the director of radiation oncology in the

1 University Hospitals of Cleveland there in the Cancer
2 Center and the Health System.

3 So when I came, we were treating in two
4 facilities, University Hospitals of Cleveland and the
5 Willoughby facility, which subsequently closed and opened --
6 we established an affiliation with the Lake University
7 Ireland Cancer Center, it is the Lake Hospital System.
8 That was in '98.

9 In '99 -- I am not clear of all the dates -- we
10 established a treatment facility called an Ireland Cancer
11 Center Southwest General Hospital.

12 In 2000, we established a treatment facility at
13 University's Westlake facility.

14 In 2001, we established a treatment facility at --
15 I am sorry, in 2000, also at Mercy Hospital in Canton,
16 again.

17 Q. So part of your administrative responsibilities
18 would be developing new centers where --

19 A. Right.

20 Q. Okay.

21 A. In 2001, we opened a facility, Chagrin Highlands,
22 part of University Hospitals, and we assumed directorship
23 of radiation oncology at the VA Hospital, that that is a
24 0.5 FTE position through the government.

25 And last week, we set up a new facility at Lorain

1 Community, the Community Health Partners.

2 Q. So is part of your administrative duties
3 supervising all these various locations?

4 A. That is correct.

5 Q. All right, anything else in your administrative
6 duties, teaching?

7 A. A small amount. I have graduate students that I
8 teach and post-doctoral students that aren't under the
9 guise of University Hospitals of Cleveland. That would
10 be under Case Western Reserve University.

11 My other responsibilities are at the Ireland
12 Cancer Center, I am the program director, and I am on
13 their board of internal advisors and support various
14 programs, clinical research.

15 I am the representative for radiation oncology on
16 several multi-disciplinary tumor boards, the
17 gastrointestinal tumor boards, sarcomas and pediatric
18 oncology, in particular. That is a weekly commitment.

19 Q. Do you have any involvement in the supervision of
20 the physics personnel?

21 A. I am technically over the -- yes, yes. So physics
22 and therapy, the research group that is over at Case
23 would be all under my direction. And there are several
24 researchers over there, there are actually -- we have
25 dramatically increased the research funding, also.

1 Q. You admit that the radiation dose of 1 Gray to
2 Joshua Valdivieso instead of 10 was a mistake?

3 A. Yes, I do.

4 Q. And you admit that giving him 1 Gray of radiation
5 for the circumstances that you were providing that
6 treatment was a breach of the standard of care?

7 MR. GROEDEL: Objection.

8 You may answer.

9 A. Well, the intended dose was 10 Gray. So yes.

10 Q. All right.

11 Doctor, I want you to educate me now on the
12 protocols, the documents that would be generated, the
13 paper trail and the people involved in treating Joshua
14 for total body irradiation under the circumstances that
15 he was.

16 First, would a physicist be involved?

17 A. Yes.

18 Q. Would a dosimetrist be involved?

19 A. Yes.

20 Q. Would a radiation technologist be involved?

21 A. Right, yes.

22 Q. Usually would a referring oncologist be involved?

23 A. Not in the delivery.

24 Q. No. I am saying, from the inception --

25 A. Yes, yes.

1 Q. -- through the conclusion.

2 A. Yes.

3 Q. All right.

4 And then there would be a consultation by the
5 radiation oncologist?

6 A. Correct.

7 Q. Would there be anesthesia involved?

8 A. Yes. In someone Joshua's age, yes. Not for
9 adults.

10 Q. Would there be nurses involved?

11 A. Yes.

12 Q. All right.

13 What I would like you to do is to tell me what the
14 role is of the physicist in these circumstances?

15 A. The physicist supervises the machine calibration,
16 the setup and the delivery of the radiation.

17 Q. Okay.

18 And what duties does the physicist execute to
19 accomplish those goals, the calibration and the delivery
20 of the radiation? In other words, you are the radiation
21 oncologist.

22 A. Right.

23 Q. You make a determination of what is the dose that
24 you want the patient to receive, correct?

25 A. Uh-huh, uh-huh. Yes.

1 Q. And walk me through, when does the physicist get
2 involved in the process?

3 A. Shall we use the specifics of Joshua?

4 Q. Yes, sir.

5 A. Well, if I can have the chart, I can -- I don't
6 have all the dates.

7 Q. You may want to look at Exhibit -- they are all in
8 there, I believe, and certainly refresh your recollection
9 with 101, but I would like you to go through Exhibit A,
10 Doc, and if you could find the corresponding record, it
11 would be easier for me to follow.

12 A. So I first met Joshua, the patient, and his mother
13 on the 6th of January of 2000.

14 Q. Can you tell me what document you are looking at,
15 sir?

16 A. I am looking at Document 6.

17 Q. Thank you.

18 And that would be the first time that you had any
19 involvement with Joshua Valdivieso?

20 A. Correct.

21 Q. And that was at the referral of Dr. Wiersma?

22 A. Correct.

23 Q. Okay.

24 A. And that is what it says, this is the initial
25 consultation, it is a four page document where I review

1 the history of the patient's presentation of disease.

2 Q. Uh-huh.

3 A. The review of systems that I obtained through the
4 mother.

5 Q. Uh-huh.

6 A. The past medical history that principally came
7 from the patient's mother.

8 Q. Uh-huh.

9 A. The social history, again obtained principally
10 from the mother, the family history, and then the
11 physical examination.

12 Q. Okay.

13 And the reason that you were seeing Joshua in
14 January of 2000 was to determine whether or not he was an
15 appropriate candidate for consolidative irradiation as
16 part of his CCG protocol for treatment of Stage IV
17 neuroblastoma; is that correct?

18 A. Correct, yes.

19 Q. And if you determined at that point in time that
20 you did not believe total body irradiation would be
21 beneficial for him, it was certainly your judgment to
22 say, I don't think this treatment has the potential to
23 help this child, correct?

24 A. I was -- the question I was asked at that time and
25 the reason for the consultation was to look at local

1 irradiation to sites of residual disease, and as well as
2 the primary site.

3 Q. Let me take the dive this way:

4 Doctor, if a pediatric oncologist refers you a
5 patient for any type of radiation oncology treatment, and
6 you determine, in your medical judgment, that it is not
7 in the best interests of the patient to undergo that
8 treatment, you can certainly say, I choose to not provide
9 this treatment to this patient?

10 A. Correct.

11 Q. All right.

12 So before you would institute any radiation
13 oncology treatment to a patient, you have satisfied
14 yourself that it is medically warranted and indicated for
15 treatment of the patient's condition, true?

16 A. Correct.

17 Q. All right.

18 So you saw Joshua on January 6th.

19 A. Right.

20 And at that time, the question that was being
21 asked was whether he would be appropriate for local
22 irradiation to sites of residual disease as well as to
23 the primary sites, which there were multiple ones.

24 He was scheduled for rescanning, actually,
25 subsequent to when I saw him. But at that time I talked

1 to the mother about the use of twice daily radiation over
2 seven treatment days, delivering 1.5 Gray fractions twice
3 daily to the total dose of 21 Gray, which was part of the
4 protocol that we were following at that time.

5 Q. All right.

6 And then did there come a time where some
7 decisions were altered and it was decided that he was
8 going to receive TBI?

9 A. The patient subsequently had a restaging in early
10 to mid January of 2000 -- this is -- yes, this is 2000 --
11 that involved an MIBG scan, which is a nuclear medicine
12 scan of a tracer element that is specific for
13 neuroblastoma, for the most part, as well as an MRI scan
14 of the skull and basically a total body MRI scan. And
15 those were subsequently performed.

16 Q. And based upon the tests, did a determination --
17 was a determination made that this child was going to be
18 provided TBI?

19 A. That is right, we had an intervening pediatric
20 oncology tumor board where that was discussed, and the
21 extent of disease was found to be too extensive to
22 consider him for the local irradiation, what I had talked
23 to the mother about on the 6th.

24 Q. Okay, so sometime after the 6th and before the
25 26th of January, some additional diagnostic testing was

1 done and then Joshua's case was presented to the tumor
2 board?

3 A. That is my recollection. I know that the
4 additional diagnostic studies were done.

5 Q. And physicians who would be present at the tumor
6 board would be specialists from pediatric oncology?

7 A. Correct.

8 Q. And your colleagues from the pediatric radiation
9 oncology, or just you?

10 A. Well, I am the only one that attends.

11 Q. The tumor board?

12 A. Correct.

13 Q. Okay.

14 What is the purpose of the tumor board, sir?

15 A. It is a management and educational discussion,
16 which in this case focuses on new patients with pediatric
17 malignancies, or we could talk about existing patients
18 where there is a potential change in the course of the
19 disease. And it is to bring together people to review
20 the new diagnostic studies or the new pathology reports.

21 So it involves pediatric pathologists, sometimes
22 hematopathologists, pediatric diagnostic radiology,
23 pediatric oncology, the pediatric oncology Fellows often
24 attend, and the pediatric residents on the inpatient
25 pediatric service often attend, and the nurses from

1 pediatric oncology, and probably half the time my nurse
2 will attend.

3 Q. Does Dr. Wiersma take notes at these tumor board
4 meetings?

5 A. I think --

6 MR. GROEDEL: Objection.

7 You may answer.

8 A. (Continuing) I don't see the notes. I think she
9 is the coordinator of the pediatric tumor board.

10 Q. Are minutes or notes taken at these meetings,
11 based upon your recollection of them?

12 A. I don't see the minutes.

13 Q. I didn't ask if you saw them.

14 A. I don't know.

15 Q. Okay.

16 A. The only thing I see is the semi -- a sheet a
17 couple days beforehand, I received it last night for the
18 cases on Thursday, that just list on Thursday there will
19 be four patients discussed.

20 Q. Does anybody from the radiation oncology
21 department, other than you, attend these tumor board
22 meetings?

23 A. No. They certainly could, but they don't.

24 Q. Would you agree with the statement that the reason
25 that you present patients' cases at tumor boards is to

1 tap into the collective expertise, wisdom, education and
2 experience of specialists knowledgeable in treating the
3 patient's disease, to discuss it amongst yourselves and
4 to come up with a collective decision of what would be
5 the best way to treat the patient's condition?

6 A. Correct.

7 Q. All right.

8 A. The other group that would be there at times would
9 be the pediatric surgeons, again depending on the
10 specific case.

11 Q. All right.

12 A. Pediatric neurosurgery, pediatric otolaryngology
13 in the case of head and neck cancers, pediatric general
14 surgery.

15 Q. Okay.

16 A. They generally don't attend the other conferences
17 if they are not -- if a specific patient of theirs isn't
18 being discussed.

19 Q. And after the presentation of Joshua's case at the
20 tumor board in January, the decision was made that Joshua
21 should receive TBI?

22 A. Correct.

23 Q. All right.

24 And you concurred in that?

25 A. Yes, I did.

1 Q. And to your knowledge, did Dr. Wiersma concur in
2 that?

3 A. Yes.

4 Q. All right, getting back to at what point the
5 physicist gets involved.

6 Now the collective decision is made how we are
7 going to approach treating this patient. You make a
8 determination TBI is the way to go. What next occurs,
9 sir?

10 A. I next meet with the mother and the patient, again
11 on the 17th of January.

12 Q. Can you show me where that note is?

13 A. That is Number 4.

14 Q. Okay, uh-huh.

15 A. The note reads, met with mother in --

16 MR. GROEDEL: Wait. He hasn't asked --

17 THE WITNESS: Okay. It is hard.

18 MR. GROEDEL: Do you want him to read his
19 note?

20 MR. MARGOLIS: Yes, please.

21 A. (Continuing) Met with mother in patient's
22 presence; in light of the number involved sites at
23 restaging by MIBG and MRI, will plan no local XRT --
24 meaning radiation therapy -- but will give TBI at 333
25 centiGray fractions q.d. times three to 1000 centiGray.

1 Q. If I can interrupt you, if I am at all up on the
2 learning curve here, that means you want the kid to get
3 10 Gray?

4 A. Exactly.

5 Q. Okay.

6 A. Discussed technique, risks, acute and late side
7 effects with mother. TBI measurements taken. TBI
8 scheduled for 1-26, 1-27, 1-28. And then I signed it.

9 Q. Doctor, what -- how many patients have you been
10 involved in that receive TBI?

11 A. Probably 350, 400.

12 Q. And how many TBI treatments are done yearly at UH
13 since you have been there?

14 A. It is a diminishing number, but I would say maybe
15 15 or 20.

16 Q. When a patient -- and you are certainly
17 knowledgeable, and as the chairman of the department, you
18 are aware of the overall process of what happens when a
19 patient receives TBI?

20 A. Yes.

21 Q. We have identified that the radiation technologist
22 is involved, a dosimetrist, physicist, nurses,
23 anesthesia. Anybody I have left out?

24 A. No.

25 Q. Is that a team approach in the treatment of a

1 patient?

2 A. During the treatment, it is a -- well, it is a
3 sequential interaction.

4 Q. Okay, but it is done as a team, to treat the
5 patient?

6 A. Not the same team.

7 Q. Not the same team, but in generality, I am talking
8 the physicist --

9 A. Right.

10 Q. -- the radiation techs, the dosimetrists, they are
11 all part of the team that is rendering care to the
12 patient?

13 A. Yes.

14 Q. Okay.

15 And I understand that they may not all be
16 providing care simultaneously, as what happens during an
17 operative procedure.

18 A. But there is not a TBI team, per se.

19 Q. I understand that. I am using team --

20 A. Right, right.

21 Q. -- to indicate it is a collective --

22 A. A group of people.

23 Q. And you would agree with me that the physicists
24 have independent responsibilities and duties to the
25 patient in the rendering of TBI care?

1 A. Yes.

2 Q. You would agree with me that the radiation
3 technologists have independent responsibilities and duty
4 to a patient receiving TBI care?

5 A. Yes.

6 Q. You would agree with me that the nurses have
7 various responsibilities and duties to a patient
8 receiving TBI?

9 A. Yes.

10 Q. Is there a system of checks and balances that is
11 designed into the system where TBI is given to a patient?

12 MR. GROEDEL: Objection. It seems sort of
13 vague, the question.

14 Q. (Continuing) Do you understand what I meant?

15 MR. GROEDEL: Are you talking about the
16 dosing checks and balances?

17 A. Is there a written procedure? I don't know of
18 any.

19 Q. Let me ask you in generality, in a patient that is
20 being administered TBI, are there any checks and balances
21 inherent in the system relative to that care --

22 MR. GROEDEL: Objection.

23 Q. -- at UH, in January of 2000?

24 MR. GROEDEL: You may answer.

25 Objection.

1 A. I am not sure if there is a written set of
2 guidelines.

3 MR. MARGOLIS: All right. Is -- excuse me
4 one minute.

5 (Pause)

6 THE VIDEOGRAPHER: Straighten out your
7 mike.

8 THE WITNESS: Okay, sorry. Bring it up
9 closer?

10 THE VIDEOGRAPHER: That is good. Thank
11 you.

12 BY MR. MARGOLIS:

13 Q. What about the general standard operating
14 procedure, whether there is written protocol delineating
15 it or not?

16 MR. GROEDEL: Objection.

17 You may answer.

18 A. I am not sure if that existed at that time.

19 Q. Okay.

20 Did it exist when you were at the University of
21 Wisconsin?

22 A. I am not sure if I was aware of one.

23 Q. All right.

24 Let's talk about the specific of dosing a patient.
25 Are there checks and balances inherent in that system?

1 A. There wasn't.

2 Q. At University Hospitals?

3 A. Right.

4 Q. In January of 2000?

5 A. Right.

6 Q. Didn't you have to sign off on various physics
7 computation sheets?

8 A. No.

9 Q. Was there any type of checks and balances inherent
10 in the system of TBI at facilities other than RB&C in
11 January of 2000 --

12 MR. GROEDEL: Object.

13 Q. -- based upon your knowledge?

14 MR. GROEDEL: Objection.

15 You may answer.

16 A. I don't know.

17 Q. Doctor, you are a nationally renowned expert in
18 your area of specialization, are you not?

19 A. Yes.

20 Q. All right.

21 You regularly lecture colleagues in your area of
22 specialization, correct?

23 A. Yes, I do.

24 Q. You have designed radiation oncology programs in
25 the course of your career, correct?

1 A. Yes, I have.

2 Q. You are knowledgeable generally about what it is
3 that is done in the, quote unquote, medical specialty of
4 radiation oncology relative to the systems used for
5 administering TBI treatment to a patient, correct?

6 A. Correct.

7 Q. In any institution that you are aware of, were
8 there checks and balances that were designed into the
9 system relative to the dosing of a patient for TBI?

10 MR. GROEDEL: Objection.

11 You may answer.

12 A. In reviewing what existed in January of 2000, I am
13 aware of, that the system was not fail-safe, obviously.

14 Q. I am not asking you, sir, the specific system at
15 UH. I am asking you in generality, given the fact that
16 you have testified of your level of expertise in this
17 area, both at UH and what was done in the, quote unquote,
18 community of radiation oncology, would a checks and
19 balance system be something that would exist in other
20 facilities, albeit not UH?

21 MR. GROEDEL: Objection.

22 If you know.

23 Q. (Continuing) That you know of?

24 A. Well, a system existed at UH, but it wasn't
25 fail-safe.

1 Q. Okay, I don't want to get in a semantic exchange
2 here.

3 I asked you if there was a check and balance
4 system that existed at UH relative to the dosing rates of
5 a patient undergoing TBI in January. You have told me
6 now that there was not.

7 A. Because --

8 Q. I didn't ask you if it was a fail-safe system.

9 A. Okay.

10 Q. Okay? I think everybody at this table has no
11 problem knowing that it wasn't fail-safe.

12 A. Correct.

13 Q. My question to you again is, in January of 2001 --
14 2000?

15 A. 2000.

16 Q. -- 2000, was there any check and balance system
17 that would have been in effect relative to the dosing
18 rates of a patient undergoing TBI at UH?

19 MR. GROEDEL: Objection.

20 I am not sure you two are connecting with
21 respect to your use of the word, checks and
22 balances.

23 Q. (Continuing) Quality control.

24 MR. GROEDEL: I mean, answer the question
25 to the best of your ability, Doctor.

1 A. Yes, I mean, there is the machine calibration, the
2 setups, the dose delivery and notes in terms of any other
3 specific technical issues. So those were checks and
4 balances. But what didn't happen is it doesn't come back
5 to the physician to see beforehand.

6 Q. So once you write the prescription for the dosing
7 rates, you are not involved with the process from that
8 point until after the treatment has been rendered?

9 A. Well, I see the patient on treatment. But I did
10 not see anything come back to me, which is different than
11 the 99 percent external beam treatment we do, where there
12 is a lot of interactions between when you see a patient,
13 and the patient then gets CT treatment plan, and then
14 simulated, and then has their ports taken, and then
15 starts treatment. There are usually four separate
16 interactions where you review things, which is not done
17 with the TBI, or was not done with the TBI.

18 Q. Would you please turn to Exhibit 15.

19 A. (Witness complies).

20 MR. MORIARTY: When you get to a convenient
21 spot, I would like to take a couple minute break.

22 MR. MARGOLIS: We can do it right now.

23 MR. MORIARTY: If this is convenient.

24 MR. MARGOLIS: This is as convenient as any
25 other spot.

1 (Short recess had.)

2 BY MR. MARGOLIS:

3 Q. Doctor, what I would like you to do, if you could
4 look at Exhibit 101, which is the original, and then if
5 you would be kind enough to cross reference it in what
6 you have there, I would like you to tell me by name and
7 title and what their responsibilities would have been,
8 each medical care provider that was involved in the TBI
9 administered to Joshua?

10 You have identified Dr. Wiersma, you have
11 identified the decision of the tumor board, you have
12 identified your involvement. I want to take it from
13 there, fair enough?

14 A. Okay.

15 Q. Okay.

16 A. So we are not referencing 16 any more?

17 Q. You can certainly reference it. I am just saying
18 that if you need to reference 101, because it may have
19 individuals who are not referenced in Exhibit 1, that is
20 fine. But if it is in fact represented in Exhibit 1, I
21 would appreciate you identifying it by the number set
22 forth in the Exhibit A binder, okay?

23 A. According to the note on the 17th, which is --

24 Q. 4?

25 A. -- Number 4, I asked a dosimetrist that day --

1 well, I was seeing the patient and the mother -- right
2 after I saw the patient and the mother, to take the TBI
3 measurements, so that would be that person.

4 Q. Do you know who that person was?

5 A. Actually, I do not know who that person was, or I
6 cannot recall.

7 And those measurements taken on that day would be
8 recorded on this Page Number 17, okay?

9 Q. Okay.

10 And what would have been the purpose of those
11 measurements that are on 17?

12 A. They take measurements of the diameter of various
13 body parts, starting under three anatomical measurements --

14 Q. Okay.

15 A. -- of head and neck, mediastinum, umbilicus, hip,
16 knee, ankle.

17 Q. All right.

18 A. And I don't -- in here, there is no signature, I
19 am not sure whose handwriting this is, so I can't tell.

20 Q. Would this basically be --

21 A. There is no date on this, either. But I assume --
22 I had asked them to do it, according to my note, on the
23 17th, so --

24 Q. Okay.

25 A. -- I assumed it was done that day.

1 Q. All right.

2 And this would not at all involve a usage or
3 calculation of the dosage?

4 A. No, no.

5 Q. Okay.

6 Who were the dosimetrists that were employed by
7 the department at that point?

8 A. David Abraham -- is it Abramson -- Abraham, I
9 think it is.

10 Q. Okay.

11 A. And Joann, I think she was still there at that
12 time. I don't recall her last name.

13 Q. Okay.

14 Was Deb Harrp at all involved in the care provided
15 to Joshua?

16 A. She is a nurse, she is my nurse.

17 Q. Was she at all involved?

18 A. During his TBI --

19 Q. At any point, sir, from when you first saw the
20 child through the treatment.

21 A. She would have seen Joshua and his mother on the
22 6th.

23 Q. Okay.

24 A. Possibly on the 17th, although I know that was on
25 a Monday, and that is usually a very busy day, she is

1 doing a lot of things that day, so I am not sure.

2 Q. Would she accompany the patient when the TBI was
3 being administered? Certainly not in the room at the
4 time it was being administered, but --

5 A. May or may not. It depends on the schedule, if
6 they are early or late. Our clinics run from around 7:00
7 in the morning to, at that time, probably 6:30 or 7:00
8 o'clock at night, so the nursing hours were often
9 staggered, so I don't know.

10 Q. Would she document any progress notes relative to
11 any care she had of the patient?

12 A. No.

13 Q. Would the radiation techs document any records
14 relative to the job they have in the TBI?

15 A. Yes, and that is documented in the chart, which is
16 listed Number 13 and 14.

17 Q. Okay, let me look at that, sir.

18 So 13 would be a document generated by the
19 radiation technologist?

20 A. Correct, 13 and 14, it is the same document, it is
21 just the other side of the page.

22 Q. Would they provide any other documentation in
23 addition to what is set forth in 13 and 14?

24 A. No.

25 Q. And would 13 and 14 be made contemporaneous with

1 the administering of the TBI --

2 A. Yes.

3 Q. -- by the radiation technologist?

4 A. Correct.

5 Q. Do we know who the radiation techs were by looking
6 at 13 and 14?

7 A. Yes, they initial.

8 Q. Where is it on 13, sir?

9 A. Therapists Initials, it is on 14.

10 Q. Okay, 14. All right.

11 And who would the therapists have been?

12 A. BS would be Barb Scott and DO would be Diane Otto.

13 Q. All right, now what about the box that says M.D.
14 Initials?

15 A. Again, that is something that I, personally, never
16 signed on any patient.

17 Q. What is it for?

18 A. I am not sure.

19 Q. So would it be that the M.D. would come down and
20 oversee the administration of TBI and then sign off?

21 MR. GROEDEL: Objection.

22 You may answer.

23 A. This is a standard form for all of our patients.
24 But again, in the four years I have been treating, I
25 can't recall ever signing that in that column. I put

1 notes in the chart.

2 Q. Do you know what its purpose is?

3 A. No, I do not.

4 Q. Why is every other box to the left of the title
5 box filled in, but the M.D. Initials are not?

6 MR. GROEDEL: Objection, asked and
7 answered.

8 Go ahead.

9 A. Well, again, it is not a policy.

10 Q. Okay, we have identified the dosimetrist. You
11 have been kind enough to point out to me which document
12 the dosimetrist authored. We also have identified the
13 radiation technologists by their initials. Do you know
14 their names?

15 MR. WALTERS: He just told you.

16 MR. GROEDEL: He told you.

17 MR. MARGOLIS: I am sorry.

18 MR. GROEDEL: Yes, he did.

19 Q. (Continuing) What about the physicists?

20 You don't need this, do you, Doctor (indicating)?

21 A. Well, I may. It is easier for --

22 Q. We will get it back, if you do.

23 A. The physicists -- there are two documentations
24 from the physicists. The first is Number 15, and the
25 second is Number 16.

1 Q. What is Number 15, Doctor?

2 A. The 15 is actually the calculation, it is listed
3 18 MV X-rays Total Body Irradiation Calculation Sheet,
4 and it says, Use Spoiler Factor, this is the standard,
5 this is the checks and balances you were asking about,
6 these are some of the checks and balances.

7 Q. Would 15 be generated by the prescription?

8 A. Yes.

9 Q. All right.

10 Now, where it says, calculated by, would that be
11 David Abrams [sic]?

12 A. DA, I assume that is his initials.

13 Q. And where it says, checked --

14 A. Right.

15 Q. -- who is that?

16 A. SAB would be Dr. Beddar.

17 Q. Who is -- and he is a physicist?

18 A. Physicist, yes.

19 Q. Sam Beddar?

20 A. Yes, Sam Beddar.

21 Q. Is he employed by Case?

22 MR. GROEDEL: Objection.

23 You may answer, if you know.

24 A. Yes, he is, but he is paid by University Hospitals
25 of Cleveland.

1 Q. All right.

2 Do you, as the chairman of the department, do
3 you -- can you, if you choose, exercise control over
4 Mr. Beddar's conduct?

5 MR. GROEDEL: Objection.

6 You may answer.

7 A. In my role as chair, I -- he is under my
8 direction.

9 Q. Okay.

10 Why would a physicist check the calculation as
11 opposed to the radiation oncologist?

12 A. Because that is what physicists do.

13 Q. Okay.

14 And would Mr. Beddar --

15 A. He is a Ph.D., he is Dr. Beddar. Ph.D. phys --
16 not a physician, he is a Ph.D.

17 Q. Okay.

18 And he has worked hard for his Ph.D. status?

19 A. Right.

20 Q. Would Dr. Beddar refer, if you know, to your
21 prescription?

22 A. Yes.

23 Q. How many patients have you worked with Dr. Beddar
24 on, where TBI was administered? Is this the first case?

25 A. I don't know. He was one of, at that time, five

1 or six physicists that could have been involved in these
2 calculation checks.

3 Q. Do you know if you had ever worked with
4 Dr. Beddar prior to Joshua Valdivieso in a patient
5 receiving TBI?

6 A. I do not know.

7 Q. Do you know if this was the first case that
8 Dr. Beddar was ever involved with, in a patient getting
9 TBI?

10 A. I do not know.

11 Q. And what is Exhibit 16, Dr. Kinsella?

12 A. 16 is a further check with in vivo measurements,
13 it was dated the 18th, but these are in vivo, they have
14 to be done during the treatment themselves, and this is
15 just to make sure -- well, these are just the phantoms.
16 They may just be running a check.

17 Q. Was this a simulation?

18 A. Well, but the patient isn't there. This is dated
19 the 18th. So they either do it, just a setup, and these
20 are calculations based on the measurements.

21 Q. Would these calculations also be dependent upon
22 the prescription that you wrote?

23 A. Yes. Although the prescription is not outlined as
24 it was on the previous page in terms of the tumor dose
25 and dose per fraction.

1 Q. Okay.

2 A. But they are both dated the same day, so --

3 Q. Doctor, did Dr. Beddar ever discuss with you the
4 dose of 1 Gray?

5 A. No, he did not.

6 Q. Would you expect a physicist discharging the
7 duties that Dr. Beddar was discharging in the care of
8 Joshua Valdivieso to bring to the attention of the
9 prescribing radiation oncologist a subtherapeutic dose?

10 MR. GROEDEL: Objection.

11 You may answer.

12 MR. WALTERS: Objection.

13 A. I would have wished he questioned that. Doses in
14 the range of 1 Gray have been given before.

15 Q. For patients with the medical profile and goals
16 that Joshua was being administered TBI?

17 A. No.

18 Q. Okay.

19 A. But pediatric and adult patients, in some
20 pediatric malignancies.

21 Q. My question is this:

22 Has there ever been a dosage of 1 Gray for TBI
23 under the circumstances of the patient profile of
24 Joshua's?

25 A. Not that I can recall.

1 Q. All right.

2 Would you, based upon your knowledge as the
3 chairman of the department, would you expect that to be
4 something that would be picked up by Dr. Beddar?

5 MR. GROEDEL: Objection, asked and
6 answered.

7 MR. WALTERS: Objection.

8 MR. NORCHI: Objection.

9 MR. GROEDEL: Asked and answered. Go
10 ahead.

11 MR. MARGOLIS: Respectfully, he didn't
12 answer. He said he wished he did, and that wasn't
13 what I asked you.

14 A. But I wrote the prescription.

15 Q. I am not asking that.

16 I am asking -- you corrected me when I referred to
17 Dr. Beddar as Mr. Beddar, and I acknowledged that he
18 certainly has a lot of training and education and
19 experience. And you told me earlier that he has
20 independent responsibilities and duties to the patient
21 under these circumstances.

22 Would you have expected him to have brought to
23 your attention the dose of 1 Gray?

24 MR. GROEDEL: Objection.

25 MR. WALTERS: Objection.

1 MR. GROEDEL: You may answer.

2 MR. NORCHI: Objection.

3 A. Possibly.

4 Q. You have no opinion -- what does possibly mean?

5 A. My point is, I wrote the prescription wrong.

6 Q. You --

7 A. And he carried out the prescription.

8 Q. Okay.

9 On its face, would you expect, under these
10 circumstances, the physicist to bring to your attention
11 the prescription of 1 Gray?

12 MR. GROEDEL: Objection, asked and
13 answered.

14 MR. WALTERS: Same objection.

15 MR. NORCHI: Objection.

16 A. Maybe. I am not sure. Yes.

17 Q. You said maybe, you said you are not sure, and
18 then you said yes. And I am trying to get you to commit
19 yourself to one of the three.

20 MR. GROEDEL: Objection. If you --

21 A. I am not sure.

22 Q. Would you -- are you responsible for QA in the
23 department that you run?

24 A. Technically, yes.

25 Q. All right.

1 Would you communicate to physicists that they have
2 some duty under a case such as this to bring to the
3 attention of the radiation oncologist that it is clearly
4 a subtherapeutic dose?

5 MR. GROEDEL: Objection.

6 You may answer.

7 MR. MORIARTY: Could you read that back for
8 me, please. I am sorry.

9 (Record read.)

10 MR. MORIARTY: Thank you. Sorry.

11 A. At that time, there was no QA policy that would
12 have brought that to the attention -- that the physicist
13 should have brought that to the attention of the
14 prescribing radiation oncologist.

15 Q. So is it your testimony that the only
16 responsibility of the physicist under these circumstances
17 is to do the computations based upon the prescription,
18 and that is it?

19 A. And to safely deliver the treatment, right. They
20 are responsible for all the technical aspects.

21 Q. In this case, did you review any of Dr. Beddar's
22 records --

23 A. No.

24 Q. -- prior to TBI being administered?

25 A. No, I did not.

1 Q. Do you have any type of routine with him, where he
2 does the initial calculations and then he sends them to
3 you with a yellow sticky on them for your approval or
4 review?

5 A. No.

6 Q. All right.

7 And in this case, it is your testimony that
8 Dr. Beddar never brought to your attention the dosage of
9 1 Gray?

10 A. Yes.

11 Q. Had he brought it to your attention prior to the
12 TBI being delivered, what would you have done?

13 A. I would have corrected the mistake on the
14 prescription and delivered the correct dose, or rewrote
15 the prescription and instructed him to recalculate it and
16 deliver the right dose.

17 Q. When Dr. Beddar is doing his calculations on this
18 case, would he have had the benefit of Exhibit 4, which
19 is your 1-17 note which says 10 Grays?

20 A. Well, he did the calculation on the 20th,
21 according to this signature, so he would have had the
22 17th.

23 Q. All right.

24 So had he chosen to review your note of 1-17, he
25 would have seen that there was a discrepancy between what

1 you said you wanted the patient to get and the
2 prescription that you wrote?

3 A. Correct.

4 Q. Okay, would you please show me the therapy
5 prescription for Joshua's TBI in Exhibit 101?

6 Doc, I am sorry, I should follow my outline a
7 little bit. Let me withdraw that and ask you another
8 question.

9 In this case, would you expect a radiation
10 therapist to know that the dose is subtherapeutic?

11 A. No.

12 Q. Isn't there a period of time that it takes to
13 deliver 1 Gray versus 10?

14 A. Yes.

15 Q. And isn't there a meter that clicks every time
16 some dosage is delivered?

17 A. Yes.

18 Q. And wouldn't the dosage of 1 Gray be significantly
19 less than the dosage of 10?

20 A. Correct.

21 Q. Are you aware in this case as to whether or not
22 any of the radiation technologists had any discussions
23 with the child's mother about how quickly the treatment
24 went?

25 A. No.

1 Q. What is the name of the piece of equipment that
2 clicks every time a dosage of administration is -- a
3 dosage of radiation is administered?

4 A. Well, there is a control panel for the linear
5 accelerator that is programmed with the dose as part of
6 that.

7 Q. Is there some audible sound that is made?

8 A. No.

9 Q. Do you know what the time would be for a dosage of
10 1 Gray that is fractionated?

11 A. The prescription was written to go to a dose rate
12 of 5 to 10 centiGray a minute. I think this machine,
13 with these calculations, typically delivers it around 7.5
14 centiGray a minute. So a hundred centiGray would be
15 about 14 minutes.

16 Q. And that would be at what total dose?

17 A. At a hundred, as I said.

18 Q. My question is, if this child had received 10
19 Grays, how long would it have taken to administer the
20 treatment on a daily basis?

21 A. About 45 minutes or longer each day.

22 Q. And based upon the prescription of 1 Gray, how
23 long would it take on a daily basis, 14 minutes?

24 A. Substantially, yes.

25 Q. Would you expect that to be something to be picked

1 up by a radiation technologist?

2 MR. GROEDEL: Objection.

3 You may answer.

4 MR. WALTERS: Objection.

5 A. They were carrying out the prescription.

6 Q. Would you expect the radiation technologists under
7 these circumstances to recognize that this was a
8 subtherapeutic dose?

9 A. No.

10 Q. Is there ever a point in medicine where nurses
11 will question the dose of a certain medicine that is
12 written by a physician because they know it to be not a
13 therapeutic dose, or do they just blindly go forward and
14 administer whatever the physician has written?

15 MR. GROEDEL: Objection.

16 You may answer.

17 MR. WALTERS: Objection.

18 A. There is possibly a situation where they should
19 question.

20 Q. All right, but that doesn't exist in radiation
21 oncology, in your opinion, under these circumstances?

22 A. No, no, it could exist, but it didn't.

23 Q. Is there any other individual that was involved in
24 the delivery of TBI to this child who we have not
25 identified?

1 A. No.

2 Q. Were there any radiation records that you removed
3 from this chart at any point in time?

4 A. No.

5 Q. When a patient is being treated for TBI, do you
6 evaluate the patient at all --

7 A. Yes.

8 Q. -- on the dates of treatment?

9 A. Typically on the first and last day, if it is
10 twice daily. In this case, it was just on the first day.

11 Q. So you evaluated Joshua on 1-26 before or after
12 his TBI?

13 A. I think it is probably afterwards, because I
14 comment he tolerated it.

15 Q. Where is your note of seeing him on 1-26?

16 A. It is in the hospital record.

17 Q. Okay, can you show that to me?

18 MR. GROEDEL: We didn't bring the hospital
19 record with us.

20 MR. MARGOLIS: Well, maybe we can break and
21 you can get it, because I asked you to bring any
22 and all records that he authored relative to his
23 treatment of Joshua, and he certainly identified
24 that as a record.

25 Q. (Continuing) So you would have seen him on the

1 26th?

2 A. Correct, that is what I wrote, a note.

3 Q. Okay.

4 And do you recall what the note indicated?

5 A. It is a short note, basically, patient was seen,
6 plan to deliver TBI at 333 centiGray fractions q.d.,
7 received first TBI dose, tolerated treatment well, and I
8 signed it.

9 MR. MARGOLIS: Marc, if you want to break
10 now, or I can come back to it later.

11 MR. GROEDEL: No.

12 MR. MARGOLIS: I need it.

13 MR. GROEDEL: I think we have it in this
14 folder here. Yes, this is the one, I think.

15 Is this it?

16 THE WITNESS: Uh-huh.

17 MR. GROEDEL: This is it.

18 MR. MARGOLIS: Yes, that is fine, if you
19 could show it to him.

20 BY MR. MARGOLIS:

21 Q. Doctor, your 1-26 note, that was done after the
22 TBI was administered?

23 A. I will read it. It identifies itself as radiation
24 oncology, because this is an inpatient hospital note.

25 Starts TBI this a.m., will receive 3 fractions,

1 then I put parentheses, one q.d. of 333 centiGray from
2 1-26 to 1-28 prior to BMT -- bone marrow transplant.
3 Tolerate at first, XRT fraction, without acute toxicity,
4 and I signed it.

5 Q. Did you review any records before you dictated the
6 1-26 note, or signed the 1-26 note?

7 A. I wrote it. Yes, I handwrote it.

8 Q. I understand that. Did you review any records?

9 A. I can't recall.

10 Q. Why would you have -- you indicate in your 1-26
11 note that he received -- that would be a therapeutic dose
12 of 10 Grays, would it not?

13 A. That was the intended dose. That is what I
14 thought he received.

15 Q. Okay.

16 Well, why -- if you are checking on the patient
17 after TBI, why wouldn't you review the records of the TBI
18 to determine whether or not he received a proper dose?

19 A. Well, it was -- the chart was in the -- both
20 charts were available. I did not check it specifically.

21 Q. That is my question, if you wanted to, the chart
22 was available for you to check on 1-26, his TBI records?

23 A. Exactly. I have seen the patient in the clinic.

24 Q. Okay.

25 And had you done that, you would have been able to

1 determine that there was an error in dosing, correct?

2 A. Correct.

3 Q. Now, Doctor, would you please pull out for me --
4 tell me this:

5 Did you see him on any date other than 1-26 after
6 TBI, either 1-27, 1-28?

7 A. I can't recall.

8 Q. If you would have, do you believe you would have
9 written a note?

10 A. Not necessarily, unless there was a change.

11 Q. Okay.

12 Now, please show me, from Exhibit 101, the
13 prescription for Joshua's TBI?

14 A. It is the top line (indicating).

15 MR. MARGOLIS: Doctor, why is it, after
16 Joshua's -- you know what? Let me get back to
17 that on clean-up, all right?

18 Marc, I don't know how you want to do it.
19 I want to mark this, to make reference to it, but
20 I don't know if you want me to put it on the
21 original, or how --

22 MR. GROEDEL: Why don't you put it on the
23 back of it.

24 MR. MARGOLIS: Fine.

25

1 (Thereupon, Plaintiff's Exhibit 102 was
2 marked for identification.)

3 BY MR. MARGOLIS:

4 Q. Doctor, handing you what has been marked on the
5 back lower right-hand corner as Exhibit 102, what is
6 that?

7 A. This is the prescription.

8 Q. For Joshua's TBI?

9 A. Right, as well as his subsequent treatments.

10 Q. And that is written in your hand?

11 A. Yes.

12 Q. Is there anyone's writing that appears on that,
13 other than your own?

14 A. Yes.

15 Q. Read it for me?

16 MR. GROEDEL: Read what?

17 MR. MARGOLIS: The writing that is not his.

18 A. I think the 18X.

19 Q. Where is it?

20 A. Under beam and energy, the second from the last
21 column.

22 Q. Who wrote 18X?

23 A. From down below, it is Dr. Beddar.

24 Q. All right.

25 And is all of the other writing yours, other than

1 18X?

2 A. Well, some things were crossed out. I don't know
3 who wrote over some of this.

4 Q. Okay.

5 Is it your testimony that on the 1-17-2000 top
6 line that says, total body irradiation, it says, Total
7 Dose (Gy)?

8 A. Yes, 1 Gy, yes.

9 Q. And something is crossed out over that, in that
10 box?

11 A. Yes.

12 Q. And that wasn't you that did that?

13 A. I can't recall. When I met with -- after the
14 lawsuit was filed, I was meeting with someone, and I made
15 marks on it unintentionally, and he corrected me.

16 Q. Okay, who were you meeting with when these marks
17 were made?

18 MR. GROEDEL: Objection.

19 Q. (Continuing) Unless Mr. Groedel advises you not to
20 answer, I am going to ask you who you were meeting with
21 when the marks that are under the first line of 1-17
22 Total Dose were made?

23 MR. GROEDEL: Well, I am going to instruct
24 him not to answer, because we believe that that
25 meeting took place in the context of quality

1 assurance/peer review and therefore is privileged
2 from discovery.

3 So if that meeting is -- if that meeting is
4 protected, then I think the identity of the person
5 involved in that meeting is protected, as well.

6 MR. MARGOLIS: Marc, I guess my question
7 would be that the discussions of the meeting are,
8 but I don't believe the attendees are. I am not
9 asking what was discussed, I just said, we have an
10 altered document --

11 MR. GROEDEL: Right.

12 MR. MARGOLIS: -- he has testified that
13 there was a witness.

14 MR. GROEDEL: I understand.

15 MR. MARGOLIS: I just want to know who the
16 witness was.

17 MR. GROEDEL: Yes. And I think, for the
18 time being, I have to take the position that I
19 cannot identify that person at this time.

20 MR. MARGOLIS: Okay, and just --

21 MR. GROEDEL: I mean, we may change our
22 mind later, and if so, I will let you know.

23 But I don't think you need that information
24 now, to continue on with your questioning about
25 this document.

1 So for the time being, the answer is, we
2 are not going to identify that individual, and you
3 can go ahead and question him.

4 MR. MARGOLIS: And just in response, so
5 that the record is complete, a significant portion
6 of this case involves an alteration of a medical
7 record, when it was made, by whom it was made. I
8 think these are some of the most pivotal issues
9 that are in dispute in this case, and there was an
10 eyewitness, and that information is not being
11 provided to me at this point in time, based upon
12 counsel's instruction of the witness to not
13 answer.

14 BY MR. MARGOLIS:

15 Q. Dr. Kinsella, was more than one person present
16 when -- well, let me ask the question this way, because I
17 think you contradicted yourself, and I want it to be
18 clear.

19 Did you author the change that is under Total Dose
20 1-17-2000?

21 A. I am not sure.

22 Q. Okay.

23 If you didn't, do you know who would have?

24 A. No, I do not.

25 Q. You may have made that change, but you don't

1 recall whether you did or whether you did not?

2 A. That is correct.

3 Q. Do you know how many changes were made in that
4 box?

5 A. No, I do not.

6 MR. MARGOLIS: May I see that original,
7 please.

8 (Thereupon, the document was handed to
9 Mr. Margolis.)

10 MR. MARGOLIS: And in going forward, it
11 should not be construed as a waiver for me to
12 redepose the witness on these issues after the
13 court rules.

14 BY MR. MARGOLIS:

15 Q. Do you always use a black pen?

16 A. No.

17 Q. In looking at the alterations that are set forth
18 on Exhibit 102, in the top box of Total Dose (Gy), does
19 that appear to you to be your handwriting?

20 A. I can't tell.

21 Q. You indicated to me that that may have been you
22 that made the change, but thereafter it would have been
23 brought to your attention that that was not something
24 that should be done?

25 MR. GROEDEL: Objection.

1 Can you restate that? I am not sure I
2 understand the question.

3 MR. MARGOLIS: Sure.

4 Q. (Continuing) I thought I heard you testify that
5 this may or may not have been you who made the change.
6 If it was you that made the change, it was brought to
7 your attention that that wasn't something that you should
8 have done?

9 MR. GROEDEL: Objection.

10 You can answer.

11 Q. (Continuing) Is that --

12 A. Correct.

13 Q. Okay.

14 Why was it that you learned that that was
15 something that you shouldn't have done?

16 MR. GROEDEL: Objection.

17 You can answer.

18 A. I was explaining to someone what the correct dose
19 should have been, and unintentionally, I wrote in -- I
20 said, this is what I should.

21 And then the person said, don't use it, don't use
22 a pen around a medical record.

23 Q. And you are indicating that this meeting that took
24 place where you may have altered the medical record, but
25 you don't know if you did, was clearly done after the

1 lawsuit in this case was filed?

2 A. Right.

3 Q. So there would be no way, if you made this
4 alteration, that it would have been apparent in the
5 medical record chart prior to July of 2001?

6 A. This -- right, this meeting was after 2000 -- July
7 of 2001.

8 Q. And no one brought to your attention that there
9 was a mistaken dose given to Joshua as part of his TBI
10 before the lawsuit was filed?

11 A. I do not recall. No one brought it to my
12 attention.

13 Q. And again, are you saying that it may have been
14 brought to your attention but you do not recall, or it
15 was not brought to your attention?

16 A. I do not recall it brought to my attention. I
17 don't remember.

18 Q. Are you aware of anybody else who would have made
19 the alterations on Exhibit 102?

20 A. I mean, this is a department record. Anyone in
21 the department could have, potentially.

22 Q. Do you know why anyone would have?

23 A. I do not. Possibly whoever wrote the anonymous
24 letter.

25 Q. So you are saying that someone may have had an

1 intention of framing you?

2 MR. GROEDEL: Objection.

3 Q. (Continuing) You make a corollary to the anonymous
4 letter. What is your thought process on this?

5 A. Anyone could have. I mean, this is in an area
6 where anyone in the department could find it.

7 Q. Well, can you testify under oath today why anyone
8 in the department would have any motivation to make this
9 alteration?

10 A. I don't know of any.

11 Q. Okay.

12 Well, what did you mean when you said it may have
13 been the person who sent the anonymous letter? Those are
14 your words.

15 A. I am not sure.

16 Q. So you said it, and you don't know what you meant?

17 A. Uh-huh.

18 Q. If Dr. Shina were to testify that he brought the
19 subtherapeutic dose to your attention before the lawsuit,
20 are you saying that he would be untruthful in that issue?

21 MR. GROEDEL: Objection.

22 You may answer.

23 A. I do not recall any conversation with Dr. Shina.
24 And there is no record of my meeting with Dr. Shina.

25 Q. So the fact that there would not be a record of

1 your meeting with Dr. Shina would mean that he wouldn't
2 have brought to your attention that this was a
3 subtherapeutic dose?

4 A. Not necessarily. But I schedule my meetings with
5 people, or my secretary does.

6 Q. Isn't it a fact, Doctor, that it was brought to
7 your attention that there was a subtherapeutic dose prior
8 to the lawsuit being filed in this case?

9 A. No.

10 MR. GROEDEL: Objection, asked and
11 answered.

12 A. (Continuing) No.

13 Q. And if other people were to testify that that did
14 happen, they would be wrong?

15 A. Right, correct.

16 Q. Would you please turn to Page 1?

17 A. In this (indicating)?

18 Q. Yes.

19 A. Okay.

20 Q. Is all this your writing?

21 A. Again, except for the 18X and the note from
22 Dr. Beddar.

23 Q. Okay, the 1 Gray is yours?

24 A. The 1 Gray is mine.

25 MR. GROEDEL: The circle?

1 THE WITNESS: I have no idea.

2 MR. GROEDEL: On the copy that you gave
3 him, there is a circle, and he doesn't know how
4 that got there.

5 MR. MARGOLIS: Yes, I didn't see it on
6 there.

7 MR. GROEDEL: That may be inadvertent from
8 your office.

9 BY MR. MARGOLIS:

10 Q. Why is there a change on the 5-10 note between
11 Page 1 and Page 2?

12 A. I noted in my records, on 5-18, the patient gets a
13 change in the prescription. So that the change from the
14 5-10 prescription reflects that on 5-18 on this chart
15 that we changed what we were doing, so we closed out that
16 prescription and wrote a new prescription.

17 Q. But you gave him, on 5-10, 35 Gys; is that correct?

18 A. That was the intent.

19 Q. Okay.

20 A. That was written in blue, it looks like.

21 Q. All right.

22 And then when was the prescription changed?

23 A. On the 18th.

24 Q. Then it would go to 17 and a half, correct?

25 A. Right.

1 Q. Well, why is it, if you look on Page 2, there is a
2 change of the 5-10 prescription, why would you change
3 what was already administered, if you are administering a
4 new dosage on 5-18?

5 A. Because between 5-10 and 5-18, Joshua only
6 received 17.5 Gray. If we were going to continue this
7 without the change that is down here (indicating), he
8 would have received 35 Gray. But indeed, he only
9 received 17.5.

10 Q. How do you know that?

11 A. Because that is what he received. On 5-18, when I
12 am doing a second simulation, I write a note, and it is
13 on 5-18 -- it is here, but I am not sure where it is
14 here. Let me see.

15 Q. I guess my question, Dr. Kinsella --

16 A. It is on Number 5, okay?

17 Q. Where are we at, 5-18?

18 A. 5-18.

19 Treatment fields modified based on MRI scan. Will
20 boost to 17.5 Gray and 7 fractions. Total dose 35 Gray.

21 Q. Okay, so that would be the dose that would be
22 changed from the 18th forward; is that correct?

23 A. Right.

24 And what that says is that prior to the 18th, if
25 you go back to the dosing, he received 17.5 Gray.

1 Q. Okay.

2 A. So the total dose I wanted to deliver is 35 Gray
3 to this boost volume.

4 Q. Okay.

5 A. So I changed the prescription from the 10th,
6 because he didn't indeed receive 35 Gray. It is updated
7 on the prescription from the 18th that he received only 7
8 of those intended 14 treatments, or he received only 17.5
9 of the intended 35 Gray.

10 Then our intent was to give the other 17.5 or
11 seven treatments to this altered volume, based on the MRI
12 scan.

13 Q. So you altered the document in the past to reflect
14 a modified prescription which would then appropriately
15 set forth what the intent was of this child to receive?

16 MR. GROEDEL: Do you understand the
17 question?

18 THE WITNESS: No.

19 MR. MARGOLIS: Would you read it back.

20 (Record read.)

21 A. Yes, that would be a standard policy.

22 Q. Okay.

23 I guess what I don't understand is why you just
24 wouldn't change the prescription on the 18th, and leave
25 the prescription that was administered to him on the 10th

1 the way it was? Because it had already been administered.

2 A. No, it hadn't.

3 Q. Okay, maybe that is where I am missing you.

4 A. Right, right.

5 So on the 10th --

6 Q. Well, on the 18th, Doctor, is when you changed the
7 prescription, correct?

8 A. Right.

9 Q. And on the 10th, what did he receive?

10 A. Between the 10th and the 18th, he received 17.5
11 Gray.

12 Q. Okay.

13 A. So on the 10th, he received 2.5 Gray, and I am not
14 sure what day of the week it is, but --

15 Q. Okay.

16 A. -- you can go back, and then the next -- until he
17 got -- he got seven treatments between the 10th and the
18 18th.

19 Q. Okay.

20 A. So then he has another MRI scan, we say, we don't
21 have to treat the entire brain, he has got bone
22 metastases, so we modify the field and modify the
23 prescription because we didn't -- what we wrote on the
24 10th, indeed by the 18th we had modified, and then we
25 wrote a new prescription.

1 Q. Okay.

2 Do you agree with me that there is no record in
3 the chart that you are able to show me that sets forth
4 that the TBI prescription that you gave him on the 17th
5 was 1 Gray?

6 A. I don't -- say that again. I didn't understand
7 that.

8 MR. MARGOLIS: Sure.

9 Could you please reread that.

10 (Record read.)

11 BY MR. MARGOLIS:

12 Q. Let me ask the question again, Doctor, try to
13 clean it up.

14 Can you show me anything in your handwriting which
15 sets forth that you prescribed 1 Gray of radiation on
16 January 17th to be administered in his TBI on the 26th,
17 27th and 28th?

18 A. Well, it looks like it is written over. I mean,
19 that says 1 Gray and 0.333 Gray.

20 Q. So Exhibit 102 -- is that what it says on the
21 back, sir?

22 A. That is right.

23 Q. You are saying that if you look at that, that that
24 is what demonstrates the 1 Gray that he was administered?

25 A. Right.

1 Q. Okay.

2 And we agree that somebody wrote over it to show
3 what the therapeutic dose was, but you don't remember if
4 it was you or not?

5 A. I do not.

6 Q. Okay.

7 Let's go the same thing, let's go the dose per
8 fraction.

9 A. Uh-huh, dose per fraction.

10 Q. There also -- that also appears to be a
11 modification on 1-17?

12 A. Right.

13 Q. Would you agree with me that your same answers to
14 my questions would apply relative to that, as well, you
15 may or may not have done it, you don't know?

16 A. Right.

17 Q. Okay.

18 Do you know how many times that was altered?

19 A. No.

20 Q. You would agree with -- yes, I will get to that --
21 you would agree with me that any alteration would be
22 unethical?

23 MR. GROEDEL: Objection.

24 You may answer.

25 A. Any intentional alteration, yes.

1 Q. How do you find the word -- define intent?

2 A. That I purposefully changed it to hide something,
3 how is that?

4 Q. Okay.

5 Is a negligent alteration violative of the
6 guidelines of UH?

7 MR. GROEDEL: Objection.

8 You may answer.

9 A. I don't know.

10 MR. MORIARTY: May I see that original for
11 one moment, please?

12 (Thereupon, the document was handed to
13 Mr. Moriarty.)

14 MR. MORIARTY: Off the record for a second.

15 THE VIDEOGRAPHER: Off the record.

16 (Thereupon, a discussion was had off the
17 record.)

18 BY MR. MARGOLIS:

19 Q. What is the protocol, if you determined that there
20 has been an error made in the dosing of a patient such as
21 these circumstances?

22 A. It generates a report called a dose discrepancy
23 form, or something like that, that is outlined, and the
24 details are briefly summarized, and it is signed by the
25 physician and reviewed by quality assurance.

1 Q. Did you ever represent to the tumor board that you
2 gave Joshua 10 Grays when you knew you had not?

3 A. No. I always thought I had given him 10 Gray in
4 the tumor boards.

5 Q. Was a dose description form or discrepancy form
6 generated based upon the treatment you provided to
7 Joshua?

8 MR. GROEDEL: Objection.

9 You may answer.

10 A. I don't know of any.

11 Q. Why wouldn't you have done so after you learned
12 that there was an error?

13 A. I learned of the error after July of 2001, and I
14 am not sure what the purpose of that would be.

15 Q. What duties do you owe the family of a patient
16 under these circumstances?

17 A. Well, I certainly will apologize when I see them,
18 but I wasn't sure if it was appropriate at this point,
19 when I learned of this, over a year after his death --

20 Q. Had you learned --

21 A. -- that I would, you know -- you know, I am not
22 sure if that is appropriate for a physician, at this
23 point, when a suit has been made, to interface with a
24 family.

25 Q. Had this been brought to your attention earlier,

1 what would you have done?

2 A. I would have met with the family, I would have
3 notified the pediatric oncologist and met with the
4 family.

5 Q. And the first time you would have informed
6 Dr. Wiersma of this mistaken dose on your behalf was
7 when?

8 A. It was when we reviewed the chart after the
9 lawsuit.

10 Q. At any point in time in your treatment of Joshua,
11 did you tell the family that you were a physician
12 operating independent of University Hospitals?

13 A. No. I have my name tag on all the time, it says
14 University Hospitals of Cleveland, and describes me.

15 Q. Who was your employer in 1999 and 2000?

16 A. Technically it is University Radiation Medicine
17 Associates.

18 Q. At all times you treated Joshua, it was on the
19 campus of University Hospitals?

20 A. Yes. That is the only place I treat patients.

21 Q. Do you have any independent recollection of
22 Joshua?

23 A. No, I do not.

24 Q. Would you agree with me that as a result of the 1
25 Gray being administered, that Joshua was denied any

1 opportunity of the benefit of TBI?

2 MR. GROEDEL: Objection.

3 You may answer.

4 A. No.

5 Q. So you believe that whatever benefit he could have
6 gotten from TBI would not have been altered had he
7 received 1 Gray versus 10?

8 A. I didn't -- my response was not to that question.

9 Q. And I know, and I followed up with another
10 question, didn't I?

11 A. Would it have changed his outcome? No.

12 MR. MARGOLIS: That wasn't the question I
13 asked you.

14 Would you read the question back to
15 Dr. Kinsella.

16 (Record read.)

17 A. (Continuing) In Joshua's situation, I don't think
18 the TBI played any -- either the 1 or the 10 Gray --
19 played any dose in -- any role in his ultimate outcome.

20 Q. Why did you then tell him to get TBI, if it would
21 have played no role in his ultimate outcome?

22 A. I think the intent and the discussions we had was
23 this was an attempt to try to delay the time to failure
24 and death.

25 Q. So let's talk about what the intent was of Joshua

1 being administered TBI.

2 A. Uh-huh.

3 Q. It was to hopefully have him go into a period of
4 remission and increase his time of survival, but not an
5 ultimate cure?

6 A. That is correct.

7 Q. Based upon him receiving 1 Gray as opposed to 10,
8 was the intent of him receiving TBI thwarted?

9 A. No.

10 Q. Then why do it at all?

11 A. Well, I think that it is not common -- it is not a
12 standard of care today, and it was an attempt to delay
13 time to recurrence, but total body irradiation is a very
14 small part of his overall treatment.

15 Q. Okay, we are talking --

16 A. His overall treatment wasn't working.

17 Q. We are talking about what the standard of care was
18 in 2000, are we not?

19 A. Correct.

20 Q. All right.

21 And it is your testimony today under oath that the
22 intent of this child receiving TBI was not adversely
23 affected as a result of him being administered 1 Gray
24 versus 10; is that correct?

25 A. In Joshua's case, yes.

1 Q. Okay.

2 A. Again, the intent was to give the 10 Gray, but I
3 don't think that it --

4 Q. But it made no difference?

5 A. I don't -- in my heart of hearts, no, unfortunately
6 not.

7 Q. But in 2000 when it was administered, you were
8 hoping it would?

9 A. The repeat restaging by the MIBG and the MRI scan
10 that were done, I think, on the 6th and the 7th and the
11 10th were pretty humbling in terms of assessing his
12 chances with anything we had.

13 Q. Doctor, did you expect this child to have the
14 potential of benefiting from TBI when it was administered
15 in January of 2000?

16 A. Yes.

17 Q. Okay.

18 And point in fact, it was represented to the
19 parents of this child that TBI would hopefully be of some
20 benefit to him, and that is why it was being administered
21 in January of 2000, correct?

22 A. Correct, correct.

23 Q. And in your opinion, the fact that there was a
24 change in a subtherapeutic dose did not in any way
25 negatively impact the intent of TBI being administered?

1 A. It may have negatively a little, but it didn't
2 mean the difference between cure or prolonged survival.

3 Q. Okay.

4 Do you think he would have died of the causes that
5 he did in June of 2000 had a therapeutic dose been
6 administered?

7 A. It would be speculation. If not June, it would
8 have been July or August.

9 Q. What chance of survival do you believe Joshua had
10 for cure?

11 MR. GROEDEL: At what point?

12 MR. MARGOLIS: January of 2000.

13 A. After the restaging? We certainly put it at less
14 than five percent, and probably realistically zero.

15 Q. When did the restaging occur?

16 A. On the 6th and the 10th of January.

17 Q. Okay.

18 A. Part of it. There may have been more.

19 Q. Have you destroyed any medical records in this
20 case?

21 A. I have not.

22 Q. At any point in time, have you gone to the medical
23 records department to review medical records in this
24 case?

25 A. No, I have not.

1 Q. So you have never gone to the medical records
2 department to obtain Joshua Valdivieso's medical chart?

3 A. No, I have not.

4 Q. When you go to the medical records department, do
5 you have to sign the chart out?

6 A. To be honest, I have never been to the medical
7 records department.

8 Q. Have you asked that Joshua's chart, hospital
9 chart, ever be brought to your office?

10 A. No. The first time I saw the chart was earlier
11 this morning.

12 Q. If you make a mistake in a medical record -- this
13 has happened to you in the past, has it not? I mean, if
14 a mistake is made in a medical record, isn't there a
15 specific procedure that is to be followed?

16 A. Usually date it and record what was done.

17 Q. And do you put error -- or cross it out and write
18 error, and then write in what is correct?

19 A. That can be the case.

20 Q. And you would have had occasion to do that prior
21 to July of 2001?

22 A. In what, though?

23 Q. In a medical record.

24 A. Say those dose administrations that we talked
25 about, if there is a misadministration, we will then go

1 back and alter the chart to reflect the right
2 administration, whether it was an underdose or overdose,
3 to then reflect what was given.

4 Q. What about in patient care medical records, if a
5 mistake is made and you cross it out and you write error
6 or void, is that something that you do, or do you just
7 cross it out and write in what you believe to be correct?

8 A. I usually would indicate an error, I wrote the
9 wrong note in a patient's chart.

10 Q. Okay.

11 A. So I had two charts there, and I wrote the wrong
12 note, so I just reflected, put wrong patient, and then
13 wrote the correct note.

14 Q. Would you agree with me, if a physician discovers
15 that they have made a mistake in the treatment of a
16 patient, they should not take steps in an attempt to hide
17 or cover up that mistake?

18 A. Correct.

19 Q. Would you agree that it would be inappropriate to
20 bill for medical services which in fact were not provided?

21 MR. GROEDEL: Objection.

22 You may answer.

23 A. Correct.

24 Q. Who was responsible for the medical records that
25 were utilized to bill for Joshua's TBI January 26th,

1 27th, 28th?

2 A. We have a billing agency that does that.

3 Q. Do you generate any records that they review?

4 A. No.

5 Q. Who does?

6 A. There is a billing specialist.

7 Q. Who are they?

8 A. It is Walt Blackam. It is a company that we still
9 use.

10 Q. Have you ever been sued for malpractice before
11 this?

12 A. No, I have not.

13 Q. Do you have any enemies in the department that you
14 can think of that would write Exhibit 19?

15 MR. GROEDEL: Objection.

16 You may answer.

17 Q. (Continuing) The reason I ask that is that you had
18 indicated that whoever wrote that may have modified the
19 chart.

20 A. Not that I am aware of.

21 Q. Have there been any complaints that have been made
22 against you during your period at University Hospitals?

23 A. None that --

24 MR. GROEDEL: Objection.

25 Q. Either by residents or other staff?

1 A. None that have been brought to my attention.

2 Q. Do you believe that Josh's period of event free
3 recurrence would have been at all altered had he received
4 a therapeutic dose of TBI, based upon what you knew in
5 2000?

6 A. I am not sure.

7 Q. Had the therapeutic dose of TBI been administered
8 to Joshua in January of 2000, would he have developed the
9 skull metastasis that he presented with in May of 2000?

10 MR. GROEDEL: Objection.

11 A. I am not sure.

12 Q. Doctor, would you go to this category, B.

13 A. Do you want this back, or where does this go?

14 MR. MARGOLIS: You can just give that to
15 the court reporter.

16 MR. MORIARTY: Unless you are pretty close,
17 within moments of being done --

18 MR. FINELLI: We are not.

19 MR. MORIARTY: When you get to the next
20 breaking point, let's take a break.

21 MR. MARGOLIS: We can take a break right
22 now.

23 THE VIDEOGRAPHER: Off the record. End of
24 Tape 1.

25 (Short recess had.)

1 BY MR. MARGOLIS:

2 Q. Dr. Kinsella, would you please go to the
3 prescription sheet in the original?

4 A. (Witness complies).

5 Q. This meeting that occurred where you may or may
6 not have made the alteration, where did the meeting occur
7 at?

8 A. It was in my office.

9 Q. How many people other than yourself were present?

10 A. Two others.

11 Q. Were the two other people that were there
12 attorneys?

13 A. No.

14 Q. Were they employees of University Hospital?

15 MR. GROEDEL: Objection.

16 You may answer.

17 A. One was.

18 Q. Who was the other?

19 A. A physician.

20 Q. Was it Dr. Wiersma?

21 MR. GROEDEL: Objection.

22 You may answer.

23 A. Yes.

24 Q. Have you discussed with Dr. Wiersma whether or not
25 she has any recollection of you altering the medical

1 records at that meeting?

2 A. No, I haven't.

3 Q. It is nothing that the two of you have discussed?

4 A. No.

5 Q. Okay.

6 You referred to the TBI dose sheet when you
7 treated the patient on 5-10 and 5-18, correct?

8 A. I don't understand the question.

9 Q. This TBI dosage sheet which we have marked on the
10 back as Exhibit 102 --

11 A. Right, yes, correct.

12 Q. -- that is an ongoing sheet, correct?

13 A. Correct.

14 Q. It is the same sheet that you utilized for his
15 prescription for the TBI on 1-17, correct?

16 A. Correct, yes.

17 Q. So whatever notations would have been on the sheet
18 on 1-17 would have been present when you reviewed the
19 sheet again to write the 5-10 dosage, correct?

20 A. Correct.

21 Q. And whatever notations would have been on the
22 sheet on 1-17 would have been present when you reviewed
23 the sheet for the 5-18 dosage, correct?

24 A. Correct.

25 Q. Why didn't you see, on 5-10, that he was given 1

1 Gray, if in fact the change to 10 Grays didn't occur
2 until after the lawsuit was filed?

3 A. Well, I didn't -- I missed it.

4 Q. You looked right at the sheet and you didn't see 1
5 Gray?

6 A. That is correct.

7 Q. Do you think -- 1 Gray for TBI in January should
8 have stood out like a flashing red light as being a
9 subtherapeutic dose to a man of your skill, education and
10 experience, true?

11 A. If I saw it, yes.

12 Q. Okay.

13 So your testimony is that you looked at Exhibit
14 102 on 5-10 and you didn't see that on 1-17, 1 Gray was
15 given?

16 A. Correct.

17 Q. And you looked at Exhibit 102 on 5-18, and you
18 didn't see that 1 Gray was given?

19 A. Correct.

20 Q. Do you think it would be more probable for you to
21 have, quote unquote, missed it, if in fact by 5-10-2000
22 the alteration had already been made?

23 MR. GROEDEL: Objection.

24 You may answer.

25 A. I don't know.

1 Q. Did you tell anybody else prior to today's
2 deposition that you in fact are the one that made the
3 alterations on Exhibit 102?

4 A. No.

5 I am not sure if I said that today. I said, you
6 know, during the meeting --

7 Q. Doctor, let me be nauseatingly clear.

8 Did you make the alterations that appear on
9 Exhibit 102 where 1 Gray turned into 10 and 0.333 turned
10 into 3.333, were those made by your hand, yes or no?

11 MR. GROEDEL: Objection.

12 A. I am not sure. I don't know.

13 Q. They may have been, you don't know?

14 A. They may have been. I cannot recall exactly.

15 Q. And you will agree with me, if they would have
16 been done by your hand, that would not have been the
17 proper thing to do?

18 A. Correct. I mean, I did it unintentionally.

19 Q. If you did it unintentionally, would you have had
20 any follow-up corresponding record that you would have
21 authored or dictated or generated to reflect that this
22 was something that was done unintentionally by you?

23 A. I did not.

24 Q. All right.

25 Do you know if these two people who were in the

1 room actually saw you alter it, if you did?

2 A. One of the persons said, don't mark that chart,
3 keep that pen away.

4 Q. Before or after you -- before or after the
5 alteration?

6 A. I can't recall. It was a person I was explaining
7 what happened, or what I thought happened, in terms of
8 writing the wrong dose.

9 Q. It presumably would not have been Dr. Wiersma who
10 said, don't alter that, keep your pen away, it would have
11 been the other individual?

12 A. That is correct.

13 Q. The chart that is on the front, Doctor, what is it
14 marked, please, the exhibit number on the front; is it
15 100 on the front of that?

16 A. Of the whole thing?

17 Q. Yes.

18 A. 101.

19 Q. 101.

20 Where is that chart normally kept in the regular
21 course of business?

22 A. Since he died, we send them out to some
23 contractor.

24 Q. Before his death?

25 A. Down in the department.

1 Q. Of radiation --

2 A. Radiation oncology, correct.

3 Q. At some point in time, have you caused that chart
4 that is marked 100 -- is it 101?

5 A. 101.

6 Q. -- to be in your office under lock and key?

7 A. Since I met with Marc Groedel in February of 2002,
8 he requested I keep the chart.

9 Q. All right.

10 I am going to request that the chart remain in the
11 offices of Reminger & Reminger and --

12 A. Sure.

13 Q. -- be under the custody of Mr. Groedel --

14 A. Where it has been since whenever you requested it.
15 I mean, I haven't had it recently. I don't know when I
16 sent it down there. It was a couple -- several weeks
17 ago.

18 Q. So the original chart has been here for several
19 weeks?

20 A. Yes.

21 MR. GROEDEL: A week or two.

22 THE WITNESS: Well, whenever, yes.

23 Somebody from your office picked it up.

24 MR. GROEDEL: We will agree to keep it.

25 MR. MARGOLIS: Thank you.

1 BY MR. MARGOLIS:

2 Q. Doctor, would you please go to Dr. Kinsella
3 Exhibit B, and turn to Page 14.

4 A. Uh-huh, I am there.

5 Q. What is -- are those your initials up on the top
6 that says, radiation oncologist?

7 A. Yes.

8 Q. Was this what you had indicated he needed before
9 it was decided that he was going to get TBI?

10 A. Yes, this was going to be part of what he needed.

11 Q. Okay.

12 Would this be rendered basically not part of his
13 radiation treatment because of the change --

14 A. Correct.

15 Q. -- to TBI?

16 A. Correct.

17 Q. Would you have expected -- strike that.

18 A lot of this stuff, we have already gone over,
19 and I don't want to duplicate.

20 Would you please turn to Page 32.

21 MR. WALTERS: Can I get a clarification?

22 Are we now on something that you are going to be
23 designating as an Exhibit B, or --

24 MR. MARGOLIS: Yes, Steve, the front says
25 Exhibit B.

1 MR. WALTERS: Okay.

2 MR. MARGOLIS: And then --

3 MR. WALTERS: And prior to this, we were
4 talking about one that says A?

5 MR. MARGOLIS: Yes, sir.

6 MR. WALTERS: All right.

7 Q. (Continuing) Page 32, sir, what is that?

8 A. This is a physics check of the whole brain
9 irradiation prescribed the day before.

10 Q. Why was not a similar sheet done -- well, strike
11 that.

12 Look at the bottom right-hand corner, it says,
13 physician.

14 A. That is right.

15 Q. Is that your signature?

16 A. Yes, it is. It is --

17 Q. Why is it that you would have signed off on this
18 physics check for his May treatment, but you would not
19 have signed off for the physics check of his January
20 treatment?

21 A. Well, that was the policy, we didn't sign off on
22 the TBI.

23 Q. Okay, but you signed off --

24 A. Right. That is why I am saying that 99 percent of
25 what we do, there is this interaction, so we see it

1 different times.

2 Q. Why is it different for TBI?

3 A. We detected a flaw after -- as a consequence of
4 this.

5 Q. Was that a flaw that was systemic just to UH --

6 MR. GROEDEL: Objection.

7 Q. -- or is that the way the community of radiation
8 oncology operates?

9 MR. GROEDEL: Objection.

10 You may answer.

11 A. I don't know.

12 Q. Would you please go to 33.

13 A. (Witness complies).

14 Q. What is this?

15 A. This is the calculations for that brain boost that
16 was prescribed on the 18th, and this is being done on the
17 19th.

18 Q. And who were the folks -- it says, Calculated by
19 J. Wright. Who is Checked by?

20 A. That is a good question. It must be a physicist,
21 but I can't recognize the writing.

22 Q. Okay.

23 When did you say he had another restaging in
24 January?

25 A. I would have to look at the records, but my

1 recollection is the MIBG scan was on the 6th or 7th and
2 the MRI scan was on the 10th or 11th --

3 Q. Okay.

4 A. -- of January, 2000.

5 Q. When you applied for privileges or employment at
6 University Hospitals, what was involved in that process?

7 A. I can't recall exactly. I assume I filled out a
8 series of forms.

9 Q. Okay.

10 And did you have meetings with anybody from UH?

11 MR. NORCHI: Objection.

12 MR. GROEDEL: You may answer.

13 A. I can't recall. I think I just submitted an
14 application form.

15 Q. All right, and you don't recall having any
16 interviews with anybody at UH?

17 A. While I was being recruited, which is --

18 Q. Well, that is what I --

19 A. Okay.

20 Q. Okay, maybe that is different --

21 A. Right, it is.

22 Q. -- than the actual --

23 A. It is different.

24 Q. Because you don't do the application until an
25 offer is extended --

1 A. Right.

2 Q. -- predicated on being credentialed.

3 A. And accepted.

4 Q. And accepted.

5 Who was -- who recruited you?

6 A. There was a search committee that was established
7 by both the Dean and the CEO of the hospital.

8 Q. Can you give me names?

9 A. Jim Willson, who is the head of the Ireland Cancer
10 Center, was the chair of the search committee. The other
11 members would have been, I think, Robert Ratcheson, who
12 is the head of neurosurgery; Marty Resnick, I think was
13 on the committee, who was the head chairman of urology;
14 and the chairman of neurosurgery. I think Tom Stellato
15 was on it, who is the division head of general surgery in
16 the department of surgery. I think someone from the
17 department, I think it was from the -- well, they were
18 forming a new department, so it didn't exist, but I think
19 it was Nancy Oleinick, who is a Ph.D. radiation biologist.
20 I am pretty sure that is it.

21 Q. Okay.

22 After you met them and they met you and the
23 decision was made that they wanted to extend an offer to
24 you --

25 A. Well, I then would have interviewed extensively

1 with other hospital personnel, but they were the search
2 committee. So they were -- but I met with Mrs. Walters,
3 Mr. Jacobs, Mr. Gray, Alan Gray was -- and most of the
4 other chairs.

5 Q. After they met you, you met them, you decided you
6 wanted to work there, they decided that they wanted you,
7 did there come a point in time where you had to go
8 through a credentialing process?

9 A. Correct.

10 Q. What did that entail?

11 MR. NORCHI: Objection.

12 MR. GROEDEL: You may answer.

13 MR. WALTERS: Objection.

14 MR. GROEDEL: I will object.

15 You can answer.

16 A. Filling out standard forms for -- I think very
17 similar to most -- many hospitals.

18 Q. At any point in time in this process, did you
19 communicate to them the investigation that we discussed
20 earlier while you were at University of Wisconsin?

21 A. They were aware of it.

22 Q. Okay.

23 How were they aware of that, sir?

24 MR. GROEDEL: Objection.

25 You may answer, if you know.

1 MR. NORCHI: Objection.

2 MR. WALTERS: Objection.

3 A. I think direct questioning. I assume they called
4 people. I don't know that for a fact.

5 Q. Okay.

6 So in the credentialing portion of your process,
7 UH was aware of the investigation that we discussed
8 earlier that involved you at University of Wisconsin?

9 A. Correct.

10 Q. Okay.

11 Did you -- and you verbally discussed that with
12 them during the process of these interviews?

13 A. Correct, as well as with the search committee.

14 MR. MARGOLIS: Okay, I am going to just
15 take one break to confer with my partner, and then
16 I think I am done.

17 THE VIDEOGRAPHER: Off the record.

18 (Thereupon, a discussion was had off the
19 record.)

20 CROSS EXAMINATION

21 BY MR. NORCHI:

22 Q. It is almost noon, Doctor. Good afternoon. My
23 name is Kevin Norchi, I briefly introduced myself
24 earlier. I represent University Hospitals of Cleveland,
25 and through that, I also represent David Abraham and the

1 respiratory -- I am sorry -- the radiology therapists. I
2 would like to follow up on some of the responses you gave
3 to questions earlier today.

4 A. Uh-huh. Yes.

5 Q. I understand that when you came to University
6 Hospitals of Cleveland, and really started practicing in
7 March of 1998, the radiation oncology department at
8 University Hospitals of Cleveland, albeit generally okay,
9 if I can use that phrase, required some further
10 development by someone of your stature to bring it in
11 line with what was going on in the rest of the medical
12 community in this country, correct?

13 A. Correct.

14 Q. And I understand that you implemented a lot of
15 changes to improve the radiation oncology department at
16 University Hospitals?

17 A. Correct.

18 Q. If you don't mind, can you outline some of the
19 changes that you implemented in the program from, say,
20 1998 through the early part of 2001?

21 A. Well, we talked in terms of developing the system,
22 and that was sort of the challenge that I was given, and
23 the responsibility, as well as developing the integration
24 of radiation oncology with the cancer center, which it
25 hadn't previously been felt to be an integral part, and

1 which it clearly should have been, and that was the
2 purpose of -- one of the purposes of recruiting me.

3 From the physician point of view, when I first
4 arrived, there were four physicians, two of which were
5 near retirement. Right now -- and today, we have 13
6 physicians. So it has increased at least threefold. And
7 the fourteenth will start in July.

8 The number of patients treated, we were treating
9 between 75 to 90 a day. We are now treating about 300 a
10 day.

11 We have refurbished a lot of equipment in terms of
12 treatment planning. The decade of the '90s introduced CT
13 scanning in radiation oncology, and this concept of three
14 dimensional conformal irradiation, which wasn't being
15 practiced here, but at that time, by the late '90s, it
16 was more or less the standard of care, and I introduced
17 that system, some of which I helped develop when I was at
18 Wisconsin under a federal grant.

19 And from the physician, I requested that we
20 specialize in areas of expertise and work with
21 multi-disciplinary cancer teams, and you know, we have
22 accomplished that. So most of the physicians that have
23 joined us since 1998 have one or two tumor sites that
24 they have principal interest in, and interface on a day
25 to day basis with surgeons, medical oncologists,

1 pathologists, diagnostic radiologists and cancer
2 biologists, for that matter, and basically are
3 responsible for contributing that part to the overall
4 comprehensive cancer center.

5 When I came, we weren't a comprehensive cancer
6 center. I think I facilitated that award from the
7 National Cancer Institute. And you had to show -- I
8 mean, it was in the so-called pink sheet from the Cancer
9 Center Review, I think in '95, that they were clearly
10 deficient in radiation oncology, and by '98, they made us
11 a comprehensive center, along with other things, but I
12 wasn't principally -- I wasn't solely responsible, but I
13 think I was a major player. So I think that is a case.

14 Nursing, we have a much better nursing system. I
15 think the nurses are now radiation oncology nurses and
16 are recognized as that, and work with individual team
17 members in terms of specific cancer sites.

18 So my nurse, Deb Harrp, interfaces with all the
19 gastrointestinal tumor patients with a series of other
20 nurses, as well as physicians. So there is a team
21 approach, and that is how cancer care is delivered today.
22 And that was my challenge.

23 And the other is to integrate the community sites
24 so that what we do at the UHC and what we do at Southwest
25 General or Mercy in Canton or now Community Health

1 Partners in Lorain or the Lake University Ireland Cancer
2 Center is, in a sense, the same, the same protocols are
3 available.

4 We have a system now that we can teleconference so
5 we can have joint rounds, they can participate. All of
6 the multi-disciplinary tumor boards occur in radiation
7 oncology because we had space, but we have become the
8 focus, I guess, of cancer care, as opposed to being an
9 ill used accessory.

10 Q. Okay.

11 Who were the four physicians who were in the
12 radiation oncology department when you joined?

13 A. Dr. Shina, Dr. Novak, Dr. Pham, and Dr. Atunez.
14 And Dr. Atunez was retired shortly after I came.

15 Q. And where is Dr. Pham, is he still --

16 A. It is a woman, it is HOUNG Pham. She is from
17 Viet Nam. She relocated to Seattle. Her husband is a
18 physician, a physical medicine specialist, they got an
19 offer to go to the University of Washington.

20 Q. And when did she go to Seattle?

21 A. In January of 2001, I think, or December of 2000.

22 Q. And is Dr. Novak still affiliated with the Ireland
23 Cancer Center?

24 A. Yes, yes, he runs the facility at LUICC, at the
25 Lake University Ireland Cancer Center.

- 1 Q. And of course, we have heard Dr. Shurin's name, he
2 is still affiliated --
- 3 A. No, Shina.
- 4 Q. I am sorry, did I say --
- 5 A. Shurin is the pediatric --
- 6 Q. Medical oncology.
- 7 A. Pediatric oncology.
- 8 Q. Dr. Shina --
- 9 A. Yes.
- 10 Q. -- is affiliated still with the program?
- 11 A. Right, he is leaving at the end of the month, or
12 early June, I am not sure when his last day is. And he
13 is taking a position in Albuquerque, where he has
14 vacationed the last 20 years. But he has accepted a
15 position there to become chairman of a department at a
16 private hospital there, I think it is called St. Vincent's.
- 17 Q. Okay.
- 18 What is Dr. Shurin's -- does Dr. Shurin hold a
19 position within the department?
- 20 A. No, she is division head of pediatric oncology, so
21 her appointment is in the department of pediatrics.
- 22 Q. I misspoke.
- 23 A. So that is her only appointment. She is not in
24 the department of radiation oncology at all.
- 25 Q. I am sorry, I misspoke. I meant Dr. Shina.

1 A. Dr. Shina.

2 Dr. Shina currently is the clinical director, and
3 he was appointed the clinical director when Dr. Michael
4 Samuels left in, I think in -- I think we appointed him
5 in either March or April of 2000.

6 Q. As part of the changes you have implemented at
7 University Hospitals of Cleveland and the Ireland Cancer
8 Center, did you also implement education strategies, if
9 you will, for the staff? You mentioned the nurses.

10 A. Right.

11 Q. Did you implement such --

12 A. Right, we have had --

13 Q. -- educational programs for radiation therapists,
14 physicists, dosimetrists?

15 A. Yes.

16 Q. Can you tell me what they were and when you did
17 that?

18 A. Well, one, there is a budget now for travel to
19 meetings that didn't exist. And the physicists,
20 dosimetrists and therapists have their own professional
21 societies, some of which have local meetings, and some of
22 which have national meetings. So that the carrot is to
23 have them present at those meetings, and then obviously
24 then to -- and they are usually sent to a meeting, one
25 meeting a year, just for being on the staff, and if they

1 are going to present or have some type of committee
2 responsibility in the national organization, then we
3 obviously support that. And the same is obviously true
4 with the physicians.

5 Q. Okay.

6 You were asked earlier about the number of
7 pediatric total body irradiations that occurred at
8 University Hospitals of Cleveland since you arrived, and
9 you gave us a number.

10 A. I am not sure if I gave you that number.

11 Q. I thought it was 10 to 15.

12 A. That was 10 to 15 patients --

13 Q. Oh, that were referred --

14 A. -- that Susan would refer to me --

15 Q. I am sorry.

16 A. -- of pediatric oncology patients in a year, from
17 her practice.

18 Q. Okay.

19 If you could, then, I will ask the question, how
20 many total body irradiations on pediatric patients were
21 performed from the time you arrived in March of 1998 to
22 January 26th, 2000?

23 A. This would be just an estimate, an educated guess,
24 but I would say probably eight a year.

25 Q. How many under your -- how many of those eight per

1 year would be under your direction as opposed to
2 Dr. Shina, for example?

3 A. The majority of them, in the pediatrics. Don did
4 the adults.

5 Q. Okay.

6 I was looking at one of the forms that were
7 prepared for the administration of total body
8 irradiation, and it indicates that the -- maybe you can
9 help me, the dose rates --

10 A. This is A.

11 Q. I am sorry, under A, Exhibit 13, for example.

12 A. Okay.

13 Q. If you look at the top, it says, Dose Rate equals
14 100 MU, I presume, per minute?

15 A. Monitor units -- I am sorry, 13?

16 Q. Yes.

17 A. Yes, monitor units per minute.

18 Q. Before January of 2000, had there been a typical
19 practice where the dose rate was higher, for example,
20 around 300, for pediatric total body irradiation?

21 A. It shouldn't have been, I mean, because the dose
22 rate is -- as we said, is 5 to 10 centiGray a minute.
23 These are just the monitor units based on the calculation
24 that day. We know above that, you get unacceptable acute
25 lung and GI toxicity. And that has been worked out at

1 St. Jude's in Seattle, going back to the '70s. So I
2 mean, it is --

3 Q. Is this dose rate, then, of a hundred, what was
4 always given, to your knowledge, for total body
5 irradiation in a pediatric patient?

6 A. I can't recall. But the dose rate in terms of
7 centiGray per minute should have been -- it can go up to
8 15, but usually you try to keep it at 5 to 10.

9 Q. Okay.

10 You mentioned that there are nurses, individual
11 radiation oncology nurses that would be assigned to a
12 particular attending physician --

13 A. Correct.

14 Q. -- is that true?

15 A. Uh-huh.

16 Q. And you mentioned Deb Harrp?

17 A. Correct.

18 Q. How long had Deb Harrp been working with you?

19 A. In -- when?

20 Q. As of January, 2000.

21 A. She may have started around that time. I would
22 have to look. I know Jill -- what was Jill's last
23 name -- worked from when I started, and then she became
24 the head nurse --

25 Q. Uh-huh.

1 A. -- okay? And the head nurse is a supervisory
2 position.

3 So I interviewed Deb Harrp, and I can't recall
4 exactly when she started. But I think it was sometime
5 late 1999, and Jill was still there as a supervisor for
6 all the nurses. But I have the busiest service, so a
7 supervisor couldn't work for me, just because they are
8 too busy.

9 Q. With respect to Joshua Valdivieso, what were Deb
10 Harrp's responsibilities in January of 2000?

11 A. With the pediatric inpatients, there would be very
12 little responsibility.

13 With an outpatient, principally outpatient
14 radiation oncology nurse, but the vast majority have just
15 had adult oncology experience.

16 So when the patients come down, there is a
17 pediatric anesthesiology -- anesthesiologist, and usually
18 a nurse anesthetist there. So any dosages, and things
19 like that, are off -- are handled by them.

20 So our nurses have very little direct supervisory --
21 supervisory nursing for those particular patients, just
22 because they are so complicated, and they often even will
23 come down with a nurse from the floor.

24 Q. Okay.

25 Would you have expected Deb Harrp to see Joshua at

1 anytime during his admission at University Hospitals from
2 January 20th through the end of the month?

3 A. Sometimes we would go up on the floor, you know,
4 mostly for a visit. But she would have no direct
5 responsibilities, there is nothing in terms of her
6 nursing care that would need to be extended to the floor.

7 Q. You would not expect her to report back to you as
8 to whether the total body irradiation had actually gone
9 forward at that time, or where Joshua was in the process
10 of the total body irradiation that you prescribed?

11 A. Well, I see her every day, we talk, you know. I
12 am not sure what that means. I mean, again, she is not --
13 that Josh had his second treatment and had his third
14 treatment, we may have said that. But I mean in terms of
15 other things, no, she is not responsible for looking at
16 the dose, for example.

17 Q. I didn't suggest that she was.

18 The question was whether or not you would expect
19 her to at least follow the progress of Joshua during the
20 total body irradiation, not to establish that the dose
21 was appropriate or not, just to let you know that the
22 total body irradiation was occurring; is that something
23 you would expect her to do or not?

24 A. Correct. But as I mentioned before, with the long
25 hours, the nursing oftentimes -- I principally see

1 patients all day Monday, Tuesday and Wednesday,
2 oftentimes from 8:30 until 6:30 or 7:00. So Deb works
3 those three long days, and then sometimes she would work
4 shorter days or not work a Thursday or Friday, because
5 the hospital says work 40 hours and they can't pay -- no,
6 I mean, that is how we set it up, so, you know, she --
7 she has agreed to that, which is --

8 Q. Okay.

9 So the hours that she works conform with what your
10 schedule requires?

11 A. Right.

12 Q. And you essentially tell her what her hours will
13 be?

14 A. No, no. She has a nurse supervisor. But it is
15 fairly predictable from week to week, of when I see -- my
16 on treatment patients are typically on Mondays, and I see
17 follow-ups on Tuesdays, and Wednesdays I see follow-ups
18 and do patients, on Thursdays and Fridays I will see some
19 new patients.

20 But you know, there is less direct clinical
21 activity on Thursdays and Fridays, so oftentimes she may
22 work for someone else during those times, or may take her
23 comp time.

24 Q. Specifically with respect to Joshua, do you know
25 whether you or Deb, separately or together, visited

1 Joshua in the hospital?

2 A. I can't recall.

3 Q. And of course, you know David Abraham, correct?

4 A. Yes.

5 Q. And he no longer works at the hospital?

6 A. Right.

7 Q. Do you recall him to be a competent dosimetrist?

8 A. Yes.

9 Q. And you had worked with him for at least a couple
10 of years; is that true?

11 A. I am not sure if he was there that long. I would
12 have to look at his record. I think he probably -- at
13 least a year, it may have been longer.

14 Q. Okay.

15 Well, during the year that you recall him working
16 at UH, he had prepared or calculated doses for patients,
17 some of your patients for whom you had given
18 prescriptions, correct?

19 A. Absolutely.

20 Q. Okay.

21 Have there ever been any occasions where he felt
22 that the dose was unusual and bring that to your
23 attention?

24 A. Possibly. I can't recall a specific, but possible.

25 Q. Okay.

1 Well, let's not make it specific with David
2 Abraham. Have there ever been any times when a
3 dosimetrist would bring to your attention what they
4 thought to be an unusual dose or an unusual prescription
5 that was written by you?

6 A. Yes.

7 Q. That is not an unusual occurrence, is it?

8 A. No, no.

9 Q. Because of your busy schedule, as you have just
10 described for us --

11 A. I would call it uncommon.

12 Q. You would call it uncommon?

13 A. Yes. Usually my technique is to write and dictate
14 very detailed notes, and often the comment from the
15 dosimetrist and the therapist is they know a lot about
16 the patient by the time they end the note. And so I try
17 to get it right the first time in so many words. So you
18 know, usually there is not a discrepancy.

19 And I tend to see more complicated patients, and
20 some unusual patients that previously hadn't been treated
21 in the department because of -- they would be referred
22 elsewhere.

23 Q. Right.

24 Well, and because of the unusual patients you
25 might see, you would also have atypical treatment plans,

1 correct?

2 A. More complicated. Maybe not atypical.

3 Q. Well, more complicated in that the dosimetrists
4 may not have seen that particular type of prescription or
5 treatment plan in the past, fair?

6 A. Correct, correct.

7 Q. Let's go back to those situations that, I mean,
8 you described as uncommon, but where a dosimetrist would
9 have a question about the dose or the prescription.
10 Would the communication with you, between you and the
11 dosimetrist, be by a Post-It note or some note stuck to
12 the chart and then the chart would be put in your mailbox?

13 A. Possibly.

14 Q. Okay.

15 A. Not my mailbox. My office, everything occurs in
16 the clinic.

17 Q. Okay.

18 A. I am there throughout the work day, four of the
19 five days. So, you know, I am in there, so oftentimes
20 they just communicate it by orally.

21 Q. But you have been in situations where there would
22 be --

23 A. Yes.

24 Q. -- a communication with a Post-It note, or some
25 other note stuck to the chart, correct?

1 A. Correct.

2 Q. And then you would respond and write on the note
3 and return it back to the dosimetrist?

4 A. Possibly, or walk it back.

5 Q. But that is one method -- that is one manner of
6 communication that would occur between you and a
7 dosimetrist, for example?

8 A. Yes.

9 Q. Is that the same -- well, would you also
10 communicate in that same way with a physicist who had
11 questions?

12 A. Possibly, but more directly by mouth.

13 Q. More typically by oral communication?

14 A. Oral communication, yes.

15 Q. Okay.

16 Have you spoken to Deb Harrp about this lawsuit at
17 all, the litigation?

18 A. No, I have not.

19 Q. And has she spoken to you about it?

20 A. No, she has not.

21 Q. You are affiliated with a practice group, it is
22 University Radiology --

23 A. Radiation Medicine Associates.

24 Q. Is that a corporation?

25 A. Yes, it was one of the -- becoming a chair here in

1 1998, you set up a corporation. It was pretty strange,
2 but anyway -- I had never done anything like that. But
3 subsequently, there is sort of a boiler plate, they are
4 all the same. But at that time, they weren't.

5 So I was responsible for it, and I actually used a
6 lawyer that had set up a practice plan before, and we
7 just sort of did it. But it was approved by the hospital
8 and the medical school.

9 Q. Sure.

10 Is it that practice plan through which you bill
11 patients?

12 A. Correct.

13 Q. Okay.

14 Are you an officer or shareholder in that?

15 A. The president.

16 Q. The president, okay.

17 Are there any other employees of the group, that
18 you are aware of?

19 A. Since we have gone into the UFPA, I think they
20 have called it now, the University Faculty Practice
21 Associates, and we have had to pick up employees, so I am
22 not sure how many there are.

23 Q. Okay.

24 A. It is a bone of contention, because we are paying
25 for things that seemingly we are --

1 Q. You don't want to have to pay for.

2 MR. GROEDEL: Doctor, just answer the
3 question, okay?

4 A. Okay, sorry.

5 Q. What is your affiliation with UFPA, University
6 Family Practice Associates?

7 A. No, no, it is University Physicians Faculty
8 Association.

9 Q. Okay.

10 A. So the family practice would be part of it, and we
11 would be part of it. So all the practice plans.

12 Q. Okay.

13 Do you, through your practice plan, provide any
14 benefits to any of the nurses?

15 A. No.

16 Q. Okay.

17 The dosimetrists?

18 A. No.

19 Q. How about the physicists?

20 A. No.

21 Q. Mr. Margolis asked you a couple of questions about --
22 well, it is Exhibit A-1, the prescription note. Let me
23 just follow up with a couple others.

24 A. Okay.

25 Q. I apologize if they are repetitive.

1 Actually, Exhibit A-2, Bates stamp Number 2 on it,
2 this is a prescription or a therapy prescription, and
3 this was filled out primarily by you, correct?

4 A. Correct.

5 Q. Okay.

6 I see your signature on the upper -- the M.D.
7 signature on the 1-17-2000 box.

8 A. Uh-huh.

9 Q. Is that written over at all --

10 A. No.

11 Q. -- on your copy?

12 A. No. It looks like the T and the K are superimposed.

13 Q. Okay.

14 Which is a little dissimilar from the one below
15 it, correct?

16 A. Right, which is dissimilar from the one below
17 that, unfortunately.

18 Q. And then I saw another signature that you make, it
19 looks like a squiggly line, it looks almost like a W; do
20 you recall that? That was from the May therapy.

21 A. Yes, I think you can look throughout, my strength
22 is not in Palmer.

23 Q. Okay.

24 One of the things that I am interested in is, when
25 you did look at this on May 10th to write a new

1 prescription --

2 A. Correct.

3 Q. -- what records and documents did you have
4 available for you when you wrote the therapy prescription
5 note here?

6 A. I would have that chart (indicating).

7 Q. Okay.

8 A. That would be it. I would have -- since Joshua is
9 an inpatient at that point, I would have his inpatient
10 records, or actually just his chart from that admission
11 from Rainbow Babies.

12 Q. From May?

13 A. From, yes, the May 10th. I assume he came in that
14 day.

15 Q. You wouldn't have the January admission?

16 A. No.

17 Q. Okay.

18 A. No.

19 MR. MARGOLIS: Excuse me, just so that the
20 record is clear, the witness motioned to that
21 chart, and I think he meant Exhibit 101.

22 THE WITNESS: 101, I am sorry. Thank you.

23 BY MR. NORCHI:

24 Q. Contained in -- would you have reviewed Exhibit
25 101 to look at the prior total body irradiation

1 treatments that were given?

2 A. Well, I may have. But --

3 Q. Is it your usual custom and practice, when a
4 patient comes in with a recurrence, to look to see what
5 prior treatment he has received?

6 A. Yes.

7 Q. Okay.

8 And the prior treatment would be reflected in your
9 chart, the Exhibit 101 that you have in front of you?

10 A. Correct, correct.

11 Q. And again looking at Exhibit 101, you would have
12 seen the calculation done by the dosimetrist and checked
13 by the physicist?

14 A. I would not have looked at that.

15 Q. Okay.

16 Do you ever look at those forms?

17 A. Yes, I -- yes.

18 Q. Under what circumstances would you look at those
19 forms?

20 A. Since I don't sign them, I have probably glanced
21 at them. I don't -- I mean, they are important
22 documents, but again, I certainly will sign off on those
23 types of things in the future, but I don't think I did
24 that day.

25 Q. Okay, I understand.

1 I am just wondering, what stage in the process --

2 A. Right.

3 Q. -- would you look at --

4 A. When I am writing a note --

5 Q. -- the calculation sheets?

6 A. Rarely.

7 Of an old calculation sheet?

8 Q. Yes. Well, in a case such as this, Joshua --

9 A. I wasn't aware, I mean, I just assumed, because I
10 am writing the note here, okay (indicating)?

11 Q. On January 17th.

12 A. Right, I am looking above -- I am writing the note
13 on 5-10, it says, see consult note, I am seeing that. If
14 you look in the front of the chart, on the face sheet,
15 you can see 10 Gray. So I mean -- and obviously in the
16 hospital record, on January 26th, I wrote the right
17 thing, I mean, it was a -- you know, an error, it was a
18 mental mistake.

19 Q. I understand.

20 A. And I carried -- unfortunately, I carried it
21 through.

22 Q. And I think you did answer this, but on 5-10 and
23 5-18, looking at Exhibit 2 on the therapy -- which is the
24 therapy prescription note, if you would have looked at
25 the top line, you would have seen that only 1 Gray --

1 A. Right.

2 Q. -- was provided, correct?

3 A. Right.

4 Technically, I should have started prescription
5 Number 2 on 5-10, a separate sheet. So I mean, this --
6 then this would have been folded back.

7 Q. Is there any reason why you didn't do that, that
8 you can think of?

9 A. It was an emergency, the child was there, probably
10 the people hadn't put the right form in. Usually one of
11 my -- the clerical people would have put a new
12 prescription in. So I open the chart, and I would see a
13 new prescription -- a whole new face sheet. And it
14 wasn't there. So it is either take down the chart and
15 ask them. The patient was under anesthesia, so I took
16 the path of least resistance.

17 Q. Was it your custom and practice to try and write a
18 note in your chart every time the patient had treatment,
19 or was it just to write a note at the beginning, and then
20 an ending note?

21 A. In patients getting weeks of treatment, we write a
22 note once a week. If there is a change or a
23 resimulation, that requires an additional note. But a
24 typical, every five fractions you write an update note.

25 Q. Okay.

1 And so the process you would have used in this is,
2 as you mentioned, you would write the January 17th note
3 that would identify the prescription, you would fill out
4 the prescription sheet --

5 A. Right.

6 Q. -- that would get passed on to the dosimetrist to
7 prepare --

8 A. Correct.

9 Q. -- the calculation?

10 A. Correct.

11 Q. And then that would be checked by the physicist?

12 A. Correct.

13 Q. And if either of them had problems or issues with
14 the dose, they would come to see you?

15 A. Correct.

16 Q. Okay.

17 And of course, you have testified you don't recall
18 any discussions with either?

19 A. Right.

20 Q. And then the physicist would then check that.

21 Who would be present at the time of the total body
22 irradiation, other than the respiratory -- I am sorry --
23 the radiation therapist?

24 A. Sometimes the physicist would be there. I mean,
25 it is ongoing, so they would be there to check the setup

1 and things.

2 Q. And what do you mean by setup?

3 A. Well, the patient is placed at three meters from
4 the radiation beam, the linear accelerators, and it is
5 actually marked out, and there is a special shield that
6 is placed in the -- between the patient and the machine,
7 plus these things called diodes, which record the
8 radiation dose, are placed on the patient at certain
9 locations. And either a dosimetrist or a physicist does
10 that, or both.

11 Q. Okay.

12 Can you tell from the record who did that in this
13 case?

14 A. Let me see.

15 On the 26th, it looks like the physicist was Sam
16 Beddar, there is no dosimetrist, and it looks like the
17 same on the -- I am not sure who was on the 28th -- or
18 the 29th -- I am sorry, on the 28th.

19 I can't tell you that, those days, specific days,
20 besides it looks like it is Sam Beddar the first day.

21 Q. I didn't have a copy of your CV, so I apologize, I
22 will have to ask this question blind, without reviewing
23 it.

24 Have you ever written any articles or made any
25 presentations regarding treatment of children through

1 total body irradiation with 1 Gray or smaller doses?

2 A. Yes.

3 Q. And when? Do you want this (indicating)?

4 A. In 1983, there is an article in --

5 MR. GROEDEL: He just asked you when.

6 A. (Continuing) Oh, 1983, sorry.

7 MR. GROEDEL: There you go.

8 Q. I am going to follow up.

9 A. It has got low-dose TBI in the title, it is in
10 Ewing's sarcoma, '83 or '84.

11 Q. Can you tell me which one it is, then?

12 A. I think I am the first author. It has got
13 low-dose -- Number 18.

14 Q. And it is an article in which you are the first
15 author, and it says, Intensive combined modality therapy
16 including low-dose TBI in high-risk Ewing's sarcoma
17 patients, correct?

18 A. Correct.

19 Q. Is there any -- well, is that article at all
20 relevant to any of the issues in this case?

21 A. Well, the doses, it was 15 centiGray twice a week
22 for five weeks at a total dose of 150 centiGray. It was
23 an experimental study carried out at the National Cancer
24 Institute of an approach using total body irradiation.

25 Q. I see from your notes of 5-11, patient notes -- it

1 is Page 4 of Exhibit A.

2 A. 5-11.

3 Q. Yes, see it?

4 A. I see a note from Deb Harrp.

5 Q. Okay, that is Deb Harrp's note?

6 A. Right. Patient, mom and dad came down to
7 radiation oncology, given teaching information, signed
8 consent and schedule of treatments. Patient will be
9 outpatient starting tomorrow. Deb Harrp, R.N.

10 Q. Okay.

11 Was the brain therapy that Joshua received
12 outpatient therapy?

13 A. It started as an inpatient, because they are
14 saying -- Deb's note says he is being discharged.

15 Q. Right.

16 A. So his first two treatments on 5-10 and 5-11 must
17 have been as an inpatient and subsequently as an
18 outpatient.

19 MR. NORCHI: Thank you, Doctor. I don't
20 have any further questions.

21 CROSS EXAMINATION

22 BY MR. WALTERS:

23 Q. For the record, I am Steve Walters, I represent
24 Case Western Reserve University and the two physicists,
25 Dr. Barry Wessels and Dr. Sam Beddar.

1 Doctor, I have very few questions at this point,
2 because most of them have been asked.

3 A. Okay.

4 Q. Which is good news for everyone.

5 If I understand, Dr. Kinsella, you do design
6 protocols for radiation therapy that are experimental on
7 occasion?

8 A. In the past, when I worked at the National Cancer
9 Institute, all of the treatment we gave was experimental
10 by design. Only patients could be treated on
11 experimental protocols at the National Cancer Institute.

12 Q. With regard to radiation therapy which you have
13 caused to be performed at University Hospitals, as a
14 comprehensive cancer center as designated by the National
15 Cancer Institute, are you on what I will, for want of a
16 better term, use, cutting edge of radiation oncology?

17 A. Yes, I would consider it today.

18 Q. And I understand that that has been through a
19 great deal of effort since you have arrived there some
20 four years ago --

21 A. Right.

22 Q. -- four and a half years ago.

23 There are protocols in which children, pediatric
24 patients, are given total irradiation of 1 Gray?

25 A. Total body irradiation of 1 Gray? No, not today.

1 Q. Not today.

2 With regard to the involvement of the dosimetrist
3 and the physicist, I want to clarify some questions that
4 were already asked, I think by Mr. Margolis, but I will
5 try not to be repetitive.

6 Am I correct that neither a -- that a physicist is
7 not permitted to write a prescription for dosage?

8 A. Correct.

9 Q. The physicists do not determine what the dosage
10 should be, that is something that is exclusively the
11 province of the radiation oncologist?

12 A. Correct.

13 Q. And in the case of Joshua Valdivieso, that was --
14 there was no difference in that arrangement?

15 A. Oh, correct.

16 Q. In fact, by law, as you understand it, physicists
17 are not permitted to make that determination?

18 A. Correct.

19 Q. You may not be familiar with the training of
20 physicists, but am I correct that they are not trained,
21 as you are trained, in determining what constitutes a
22 therapeutic dose for various cancers?

23 A. Correct.

24 Q. And if a physicist were to question your judgment
25 on what is therapeutic or subtherapeutic or, moving to

1 the other direction, toxic, that is not an appropriate
2 thing for a physicist to do, is it?

3 A. They could question it.

4 Q. How would you receive them questioning your
5 judgment about what is appropriate dosage?

6 A. I would explain the reason why I prescribed that
7 dose.

8 Q. Has that happened since you have been at
9 University Hospitals, where either a physicist or a
10 dosimetrist have questioned your dosage, and you have
11 explained to them why that was the correct dosage?

12 A. Yes.

13 Q. Obviously you don't have the time to do that on
14 every case?

15 A. Oh, correct.

16 Q. It wasn't clear to me, but if I am correct, Joshua
17 was scheduled to receive his total body irradiation in
18 three fractions?

19 A. Correct.

20 Q. And they were scheduled to be done on January
21 26th, 27 and 28?

22 A. Correct.

23 Q. Would you have seen Joshua on each occasion when
24 he was there to receive a fraction?

25 A. I am not required to see him. I usually would see

1 him.

2 Q. In this specific case, do you recall whether or
3 not you did?

4 A. I saw him on the 26th and wrote a note for sure.

5 Q. Okay.

6 And that is the note you referred to before that
7 is in apparently the University Hospitals chart?

8 A. Right.

9 Q. And you may have answered this, bear with me.
10 That was put in the University Hospitals chart rather
11 than in your departmental chart, Exhibit 101, for what
12 reason?

13 A. Joshua was an inpatient, and I am communicating to
14 the inpatient team what we are doing in the radiation
15 oncology clinic, which, as you know, is a long way from --
16 and the expectation, so that they know they are
17 scheduling his bone marrow transplant three days from
18 now.

19 Q. And typically is that the way it works, when a
20 patient is being seen or treated in your department as an
21 outpatient, the record keeping is done in your
22 departmental record, such as Exhibit 101?

23 A. Correct.

24 Q. And when they are an inpatient, the records --
25 record keeping or notations are made in the hospital

1 chart?

2 A. Sometimes both places. We are communicating to
3 different groups. If I am communicating the schedule
4 that is important for the floor and physicians on the
5 floor to know, I would give that information. If there
6 was another bit of information, say, scheduling a second
7 simulation, that the floor would not know what those
8 words meant, I would simply put it in our chart.

9 Q. Now, I noticed in the case of Joshua, you dictated
10 a lengthy note that was then typed up for your encounter
11 of January 6th, 2000, and I think you were asked
12 questions about it, correct?

13 A. Correct.

14 Q. And then I noted also that you dictated a note,
15 not quite as lengthy, but still a fairly lengthy note on
16 May 10th?

17 A. Correct.

18 Q. What is the criteria by which you decide when to
19 dictate a note as opposed to just write a note out?

20 A. Well, a consult note is often long, and I haven't
21 got the time to write it. So usually I will write --
22 sometimes I will write a brief note, but say, full note
23 dictated. I will then give it to my secretary, and
24 usually we put it in the chart that day. So they
25 actually have that, and it is appreciated, because it is

1 much more detail, and it can be read, it is legible.

2 Q. In, I guess Plaintiff's Exhibit A that we have
3 been making reference to periodically in this deposition,
4 on Page 4, there is your handwritten note of January
5 17th?

6 A. Correct.

7 Q. Am I correct that the treatment plan as of January
8 17th was different than the treatment plan contemplated
9 when you dictated your January 6th note?

10 A. Correct.

11 Q. And I think you explained that, there had been
12 some additional staging, and to put it in layman's terms,
13 this was a worse situation than you had anticipated?

14 A. Correct.

15 Q. There are no other notes until there is one
16 beginning 5-10?

17 A. Right, correct.

18 Q. Am I correct that when that says 5-10-99, that is
19 a mistake, of course?

20 A. That is correct.

21 Q. It is 5-10-2000?

22 A. 2000, yes.

23 Q. By 5-11, that -- somebody -- well, I guess you,
24 pick up the mistake and begin using the proper year?

25 A. That is Deb Harrp's note, but that is the correct

1 year, yes.

2 Q. Okay, all right.

3 A. By 5-16, I picked it up.

4 Q. All right.

5 Which is on Page 5 of Exhibit A?

6 A. On Page 4, 5-16 note.

7 Q. It is 4, okay.

8 Dr. Kinsella, turning to Page 1 of Exhibit A --

9 A. Yes.

10 Q. -- this is the prescription, there has been talk
11 about prescription. This is the prescription, correct?

12 A. Yes.

13 Q. And only a physician can write that?

14 A. Correct.

15 Q. And it is the prescription that then triggers the
16 calculations that the various people go through as far as
17 setting up the machine, calculating how to deliver the
18 radiation?

19 A. Right, correct.

20 Q. We talked a lot about the line for January 17th on
21 Exhibit 1, which you have indicated contains a total dose
22 of 1 Gray, and should have been 10 Gray, correct?

23 A. Correct.

24 Q. Down below that is -- the very next prescription
25 you wrote was on May 10th?

1 A. Correct.

2 Q. And on Exhibit 1, that says 35 Gray?

3 A. Correct.

4 Q. So -- and that is your signature or initials to
5 the right, correct?

6 A. Yes, it is.

7 Q. So when you wrote that, you would have seen your
8 earlier prescription, correct?

9 A. Should have. I mean, it was there.

10 Q. Understand. Yes, I am not quibbling with words.

11 Would that have been the first time you would have
12 had the occasion to see that 1 Gray prescription of
13 January 17th?

14 A. Well, I saw that I wrote a note on the 26th in the
15 hospital chart, so this chart would have been available
16 during the treatment. But after the total body
17 irradiation was given, I did not see Joshua in follow-up
18 at any time, so this would have been the next time I
19 would have seen this.

20 (Thereupon, Mr. Margolis left the room.)

21 Q. Let me ask you this:

22 Would there have been any -- have been any reason
23 for you to make reference to the therapy prescription
24 sheet between January 17th and May 10th?

25 A. During the treatment itself, the TBI, I certainly

1 could have seen it and should have seen it. So while he
2 was getting treatment, and while I wrote the note in the
3 chart, the hospital chart, the patient and the radiation
4 oncology record are usually there in the outpatient
5 clinic.

6 Q. Now --

7 A. I can't recall whether I specifically had this
8 chart in front of me when I wrote that note in the
9 hospital chart.

10 Q. But when you wrote the May 10th prescription,
11 obviously since it is only two lines below, or an inch
12 away, you did have it front of you?

13 A. Yes.

14 Q. Sure.

15 Exhibit A-2, which is the next page --

16 A. Yes.

17 Q. -- there is -- and I think you have explained
18 this -- the 35 Gray for the May 10th prescription is
19 crossed out and there are some other numbers put in and
20 circled. That is your writing, correct?

21 A. Yes.

22 (Thereupon, Mr. Margolis reentered the
23 room.)

24 Q. And the total number of fractions are changed from
25 14 to 7?

1 A. Correct.

2 Q. And that is your changes?

3 A. Yes.

4 Q. Those changes were made at the time -- and I am
5 drawing the distinction between that and the situation
6 you described earlier in response to Mr. Margolis'
7 questions about something done after the lawsuit.

8 That was done -- the changes for May 10th were
9 done intentionally and at the time Joshua was under
10 treatment?

11 A. They were done on 5-18.

12 Q. Okay.

13 In doing that, you would have again had the
14 opportunity to see the 1 Gray prescription that you had
15 written back on January 17th?

16 A. Correct.

17 Q. If you compare Exhibit A-2 with Exhibit A-3 --

18 A. Yes.

19 Q. -- is there any change to the prescription sheet
20 between those two, other than what you have already
21 testified to, and that is the change that was made after
22 the suit was filed on the January 17th prescription?

23 A. Not that I can see.

24 Q. I haven't seen any, either, but I thought maybe
25 you might pick it up if I have missed it.

1 A. (Witness shakes head).

2 Q. Would you agree that a radiation oncologist is
3 more apt to recognize the inappropriateness of a
4 radiation dose than would be a nonphysician?

5 A. Oh, absolutely.

6 Q. Now, you gave testimony in response to questions
7 by Mr. Margolis with regard to the prognosis for this
8 young man.

9 A. Yes.

10 Q. Am I correct in my understanding of your testimony
11 that at least as of the time that Joshua was restaged in
12 early January of 2000, his prognosis was rather dismal?

13 A. Correct.

14 Q. And I think you already quoted some statistics
15 with regard to that.

16 A. I gave an estimate --

17 Q. Yes.

18 A. -- my estimate.

19 Q. Am I correct that in your practice as a radiation
20 oncology -- oncologist, the fact that a given patient's
21 chances of survival, even with cutting edge therapy, the
22 most appropriate therapy available, is poor, you will
23 not, on that basis alone, deny them the at least possible
24 benefit of receiving the therapy?

25 A. Correct.

1 Q. And in the case of Joshua Valdivieso, it was that
2 view of giving him whatever chance, albeit small that he
3 had, that you agreed to provide him with total body
4 irradiation?

5 A. Correct.

6 Q. Is there some rule of thumb as to the duration of
7 time, or the period of time over which fractions must be
8 given if they are to have any salutary effect on a
9 patient?

10 A. Well, typically radiation is given once a day, in
11 some settings, it is given twice a day. And we think the
12 delays in radiation -- and there is information to
13 suggest that, that intentional breaks can have an adverse
14 outcome. So prolonging a course of treatment for various
15 reasons, this is principally in adult cancers, cervix
16 cancer and lung cancer.

17 Q. Am I correct that as you look at the case of
18 Joshua Valdivieso, at least from the standpoint of
19 radiation oncology, the dosage given, the time given, the
20 fractions given, in all probability made no difference in
21 terms of his ultimate outcome, which was to succumb to
22 his cancer?

23 A. That is what I believe.

24 Q. Dr. Kinsella, both before Joshua Valdivieso and
25 after Joshua Valdivieso, have you had occasions to work

1 on cases in which either Dr. Barry Wessels or Dr. Sam
2 Beddar have been involved?

3 A. Yes.

4 Q. Have you found them to be competent and
5 conscientious physicists?

6 A. Yes.

7 Q. Were your responses to any of the questions by
8 Mr. Margolis intended to indicate that you believe that
9 in the case of Joshua Valdivieso, either Dr. Wessels or
10 Dr. Beddar fell below the standard for physicists?

11 A. Absolutely not.

12 MR. WALTERS: That is all I have.

13 MR. MORIARTY: Do you have more than five
14 minutes?

15 MR. SWEENEY: No, probably not, actually.

16 MR. MORIARTY: Do you have more than five
17 minutes?

18 MR. MARGOLIS: Yes.

19 MR. MORIARTY: Then I need five minutes.

20 (Thereupon, a discussion was had off the
21 record.)

22 (Short recess had.)

23 MR. MARGOLIS: Doctor, did you indicate --

24 MR. GROEDEL: Wait, Tim had questions.

25 MR. MARGOLIS: What?

1 MR. WALTERS: Wait your turn.

2 DR. WIERSMA: Wait your turn.

3 MR. MARGOLIS: Oh, I am sorry, Tim, I
4 apologize.

5 MR. SWEENEY: That is okay, as it is going
6 to turn out, you might as well go ahead. After
7 looking at my notes, I am going to pass.

8 Thanks, Doctor.

9 (Thereupon, a discussion was had off the
10 record.)

11 RECROSS EXAMINATION

12 BY MR. MARGOLIS:

13 Q. Doctor, is it Dr. Shina who you said is leaving to
14 go to Mexico?

15 A. Correct. New Mexico.

16 MR. MORIARTY: New Mexico.

17 A. (Continuing) New Mexico, Santa Fe.

18 Q. All right.

19 Going back to this meeting where you may or may
20 not have altered the record and Dr. Wiersma was present,
21 you were aware certainly prior to today that one of the
22 allegations in this lawsuit involved an alteration of
23 records?

24 A. Uh-huh, right.

25 Q. And Dr. Wiersma purportedly would have been a

1 witness as to whether or not you would have altered the
2 record at this meeting after the lawsuit was filed.

3 You are testifying today that you have never
4 discussed with Dr. Wiersma what her recollection is of
5 whether or not you altered the records at this meeting
6 after the lawsuit was filed?

7 MR. GROEDEL: Objection.

8 First of all, any conversations that
9 Dr. Kinsella had with Dr. Wiersma would be
10 protected by spousal privilege. So I am going to
11 instruct him not to answer the question just based
12 on that basis alone.

13 MR. MARGOLIS: Except if she is going to
14 testify as to what she saw, then that portion of
15 the privilege is going to be abrogated by her, and
16 I can certainly ask him what his understanding is
17 of her knowledge.

18 Q. (Continuing) Let me phrase the question this way:
19 Because you and Dr. Wiersma are married, there is
20 a legal privilege that applies. We will argue it in
21 front of the judge, and the judge will make a determination.

22 For the purposes of my questioning today, do you
23 have knowledge as to whether or not Dr. Wiersma recalls
24 you altering the record, which is record 102, at this
25 meeting that occurred after the lawsuit was filed?

1 MR. GROEDEL: Objection.

2 You may answer, if you know.

3 A. I am not sure if she was there at that time.

4 Q. Okay, all right.

5 You have been involved in pediatric oncology and
6 radiation oncology for how many years?

7 A. Since 1980, when I went to the National Cancer
8 Institute.

9 Q. Have you ever known children to beat the odds,
10 that there are successes or miracles that medically you
11 just say, no chance, not going to happen?

12 MR. GROEDEL: Objection.

13 You may answer.

14 MR. WALTERS: Objection.

15 MR. NORCHI: Objection.

16 A. Not really. I mean, unfortunately, they often are
17 predicted by -- by the disease status. So we know pretty
18 well what will happen.

19 Q. One hundred percent of the time?

20 MR. GROEDEL: Objection.

21 You may answer.

22 MR. WALTERS: Same objection.

23 MR. NORCHI: Objection.

24 A. We are pretty sure most of the time.

25 Q. That isn't what I asked, though.

1 Have there ever been children who you believe,
2 based upon your skill, education, knowledge and
3 experience, that they are not going to survive secondary
4 to their disease beyond a certain time period, and lo and
5 behold, they surprise everybody and they do?

6 MR. GROEDEL: Objection to the vagueness of
7 the question --

8 MR. WALTERS: Objection.

9 MR. GROEDEL: -- but you may answer.

10 MR. NORCHI: Objection.

11 A. Theoretically.

12 Have they lived longer than I might have guessed?
13 Yes. Have they been cured? Probably not, unfortunately.

14 Q. Now, if a patient, a child, has an extremely poor
15 prognosis, and you don't really anticipate that the
16 medical treatment that you are providing is going to have
17 any meaningful impact upon the patient's prognosis either
18 for cure or survival, is that something that you are duty
19 bound to inform the parents of so they can make an
20 informed choice of treatment?

21 A. In that setting, those -- as you have phrased the
22 question, I would say yes.

23 Q. All right.

24 And your testimony is that after you saw Joshua
25 and you had this detailed note of January 6th, that you

1 saw him again on January 17th where, based upon his
2 medical condition and modifications, that there was a
3 change from your perspective what would be most
4 appropriate treatment, and it would be TBI, correct?

5 A. Correct.

6 Q. And your only January 17th note is what is on Page
7 4 of Exhibit A, correct?

8 A. Correct.

9 Q. At any point do you document that you informed
10 Joshua's parents that you really didn't think that this
11 treatment was going to have a snowball's chance in hell
12 in benefiting this child?

13 MR. GROEDEL: Objection.

14 You may answer.

15 Q. (Continuing) Is that documented anywhere in your
16 January 17th note? Look at the note.

17 A. No.

18 Q. As a matter of fact, on January 20th -- if you
19 want to go to Dr. Wiersma, and look at Page 4.

20 MR. WALTERS: We don't have this.

21 MR. MORIARTY: What is the exhibit number?

22 MR. MARGOLIS: 4.

23 MR. GROEDEL: Is this going to be marked as
24 an exhibit? This is something we haven't seen.

25 MR. MARGOLIS: Right, I am going to give --

1 I will mark it as an exhibit. Let me do this --

2 MR. MORIARTY: I am just saying, the other
3 ones had a letter, A, page something --

4 MR. MARGOLIS: Right.

5 MR. MORIARTY: -- B, page something. What
6 is this one?

7 MR. MARGOLIS: This does not have a letter,
8 because there is only one folder that is
9 delineated Dr. Wiersma.

10 MR. MORIARTY: Okay.

11 MR. MARGOLIS: It is marked Exhibits 1
12 through 32.

13 Q. (Continuing) So I am handing you the Dr. Wiersma
14 folder, and asking you to refer to Page 4.

15 A. Yes.

16 Q. And at that point, was it not represented as
17 following to the parents: "It is hoped that this procedure
18 will benefit my child. There is no guarantee that my
19 child will experience a continued remission. It is hoped
20 that the radiation and high-dose chemotherapy will kill
21 tumor cells. It is hoped that the combined treatments
22 will increase my child's chance to remain well. It is
23 hoped that the treatment will decrease the risk that the
24 tumor will return or relapse." And then that is signed
25 by the child's parents on January 20th of 2000?

1 A. Yes.

2 Q. All right.

3 So with everything that all the doctors knew
4 that were taking care of Joshua in January of 2000,
5 you never said to the parents, I think that this TBI
6 is hopeless, or we don't have any hope whatsoever that
7 this will benefit your child; it was represented that
8 this could have a potential benefit to this child, wasn't
9 it?

10 A. Yes.

11 Q. And if you would have thought in January of 2000
12 that TBI had absolutely no chance of benefiting this
13 child, it would have been medically unethical for you to
14 administer that treatment?

15 A. I didn't say that.

16 Q. I didn't ask you what you said. I asked you to
17 answer what I asked.

18 Would you read the question back.

19 A. Yes, please.

20 (Record read.)

21 A. (Continuing) Yes, correct.

22 Q. And you would agree with me that it would have
23 been unethical for any other health care professional to
24 have recommended the treatment under these circumstances
25 if the consensus of opinion was there was no chance that

1 this was going to help this child?

2 A. Yes.

3 Q. Has your status at University Hospital been
4 changed at all relative to the filing of this lawsuit,
5 have you been put on probation?

6 A. No.

7 Q. Are you aware as to whether or not there is any
8 impending investigation surrounding your potential
9 summary suspension based upon the facts of this lawsuit
10 and deposition?

11 MR. GROEDEL: Objection.

12 A. No, I do not.

13 Q. There was a physicist who you testified had left,
14 or a dosimetrist, I believe, Mr. Abrams [sic]?

15 A. Yes.

16 Q. Where did he go?

17 A. I think he is at Akron City Hospital now.

18 Q. Have there been instances in the course of your
19 practice where you have told patients' parents, I just
20 simply will not do any more treatment on this child
21 because it doesn't have any -- it is not medically
22 warranted --

23 A. Yes.

24 Q. -- if there is no chance of benefit?

25 A. Yes.

1 Q. And that is something that you believe, as a
2 physician, you have the obligation to do if the situation
3 merits it?

4 A. Yes.

5 Q. The last question I have, if you look at -- or
6 line of questioning. If you look at 10- I think it is
7 -2, which is the prescription sheet --

8 A. Yes.

9 Q. Is it 102, sir?

10 A. Let me see.

11 MR. GROEDEL: Yes.

12 A. (Continuing) Yes.

13 Q. I thought you said earlier that normally every
14 time a prescription is written, that it is written on a
15 separate piece of paper, that it is not done
16 sequentially; is that accurate? Was that your testimony?

17 A. When I came, we would do -- when I started at UH
18 in 1998, we would do it on the same, and then some
19 patients would carry over. It got to be very sloppy and
20 hard to follow.

21 So a policy was made that if a patient comes back
22 for a retreatment or a second treatment, then the
23 clerical staff, and things like that, should reorganize
24 the chart with a new prescription sheet, and then this
25 would go behind that.

1 Q. All right.

2 And when did that change in policy take place?

3 A. I am not sure whether it was before or after this
4 time.

5 Q. All right.

6 A. But in today -- today, there would have been a
7 fresh sheet here that I would have then put, whole brain,
8 it would have been Number 2, and the stage would have
9 changed, it would be X, it would be relapse, so some
10 things would have changed.

11 Q. You indicated in answer to Mr. Norchi's questions
12 that in May, when you did additional prescriptions for
13 radiation, that you would have reviewed the child's chart
14 inclusive of the January treatment that he had received,
15 correct?

16 A. I may have.

17 Q. Well, what would be your standard operating
18 procedure under these circumstances? You have a child
19 with a remission, the child has --

20 A. Right.

21 Q. -- been previously treated with radiation.
22 Wouldn't you want to look at what the prior radiation
23 treatment was before you determined what treatment you
24 were going to recommend now?

25 A. Yes, yes.

1 Q. All right.

2 A. And -- but my -- it was 10 Gray, and it was here
3 (indicating), and it is on that note. So that is -- I
4 mean, that is how I saw it. I mean, it was a mental
5 lapse.

6 Q. I understand that.

7 A. And --

8 Q. And it is your testimony today under oath that had
9 anybody brought to your attention that Joshua Valdivieso
10 did not receive 10 Gray of radiation during his TBI on
11 January 26th, 27th and 28th, if anybody would have
12 brought that to your attention, you would have advised
13 the parents of the fact and evaluated whether or not a
14 change in his medical treatment would have been
15 warranted?

16 A. Right.

17 Q. And the first time that you knew that this child
18 received 1 Gray was after the lawsuit in this case was
19 filed?

20 A. Correct.

21 MR. MARGOLIS: Thank you.

22 MR. NORCHI: I have just one follow-up
23 question.

24 MR. MORIARTY: No.

25 MR. NORCHI: Please? One subject.

RE CROSS EXAMINATION

BY MR. NORCHI:

Q. Doctor, I would like to just follow up on an answer you gave to a question by Mr. Walters.

A. Uh-huh.

Q. You told us that -- you have testified today that you have no criticisms of the physicists who were involved in the care of Joshua Valdivieso in January, correct?

A. Correct.

Q. By the same token, would it also be true that you have no criticisms of the care or the participation in the care of Joshua Valdivieso by the dosimetrist, David Abraham?

A. Correct.

Q. The radiation therapists?

A. Correct.

Q. And the nurses, in particular Deb Harrp?

A. Yes.

Q. Okay.

No criticisms of any of their participation?

A. No.

MR. NORCHI: Thank you.

MR. GROEDEL: Okay.

MR. WALTERS: I have no questions.

1 MR. GROEDEL: Oh, I am sorry, Steve.

2 MR. WALTERS: Well, I have none.

3 MR. GROEDEL: Oh, you have none. I am
4 sorry.

5 MR. MORIARTY: He will read and sign.

6 - - -

7 (DEPOSITION CONCLUDED)

8 - - -

9
10 Timothy J. Kinsella, M.D.

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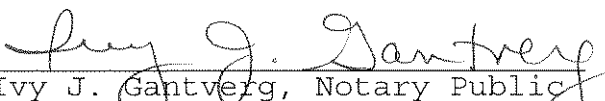
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1 CERTIFICATE

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

4 I, Ivy J. Gantverg, Registered Professional
5 Reporter and Notary Public in and for the State of Ohio,
6 duly commissioned and qualified, do hereby certify that
7 the above-named TIMOTHY J. KINSELLA, M.D., was by me
8 first duly sworn to testify to the truth, the whole
9 truth, and nothing but the truth in the cause aforesaid;
10 that the deposition as above set forth was reduced to
11 writing by me, by means of stenotype, and was later
12 transcribed into typewriting under my direction by
13 computer-aided transcription; that I am not a relative or
14 attorney of either party or otherwise interested in the
15 event of this action.

16 IN WITNESS WHEREOF, I have hereunto set my hand
17 and seal of office at Cleveland, Ohio, this 6th day of
18 May, 2002.

19
20 
21 Ivy J. Gantverg, Notary Public
22 in and for the State of Ohio.
23 Registered Professional Reporter.

24 My commission expires November 5, 2003.
25

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