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

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IN THE COURT OF COMMON PLEAS

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Iwona Valdivieso, etc., Plaintiff,	)	
vs.	)	Case No. 443978
University Hospitals of Cleveland, et al., Defendants.	)	Judge Mannen

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DEPOSITION OF TIMOTHY J. KINSELLA, M.D.

WEDNESDAY, MAY 1, 2002

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

APPEARANCES:

On Behalf of the Plaintiff:

Ronald A. Margolis, Esq.
Daniel M. Finelli, Esq.
Finelli & Margolis
730 Leader Building
Cleveland, Ohio 44114

On Behalf of Defendant University Hospitals of Cleveland:

Kevin M. Norchi, Esq.
Moscarino & Treu
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On Behalf of Defendant Dr. Shina:

Timothy G. Sweeney, Esq.
Bonezzi, Switzer, Murphy & Polito
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Cleveland, Ohio 44114

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

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

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

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

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

Matthew P. Moriarty, Esq.
Brzytwa, Quick & McCrystal
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Also Present:
Susan Wiersma, M.D.
Barry Hersch, Videographer

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

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

TIMOTHY J. KINSELLA, M.D.

a defendant herein, called by the plaintiff for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

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

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

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

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

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

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

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

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

CROSS EXAMINATION

BY MR. MARGOLIS:

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

A. No.

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

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

Q. Okay.

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

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

Q. Okay.

A. I think I was representing the physicians.

Q. All right.

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

A. I think there are three or four.

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

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

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

A. That is right, that is correct.

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

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

Q. All right.

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

A. Yes, as of April of 2002.

Q. Thank you.

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

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

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

MR. MARGOLIS: Okay.

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

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

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

BY MR. MARGOLIS:

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

A. Yes.

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

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

Q. And is that the original chart, sir?

A. Yes, it appears to be.

Q. All right.

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

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

Q. All right.

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

A. No, I do not.

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

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

BY MR. MARGOLIS:

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

A. Yes.

Q. Have any records been removed from that chart?

A. No, they have not.

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

A. No, I do not.

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

MR. MARGOLIS: Okay.

BY MR. MARGOLIS:

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

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

A. No, there have not.

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

A. No, I did not.

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

A. No, I did not.

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

A. I was aware of them.

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

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

office or I don't keep them.
Q. As the chairman of the department, though, would you have some administrative responsibilities?
A. Yes, I do. And those records would probably be in the administrator's office.
Q. I also asked you to bring certain documents which were generated relative to an investigation that was performed at the University of Wisconsin Medical School Department of Human Oncology involving yourself during the years 1996 and 1997. Do you have any documents in your possession that were generated as a result of that investigation?
A. No, I do not.
Q. Were you ever forwarded any letters or documents by Phillip Farrell relative to that investigation or any decisions made as a result of that investigation?
A. I may have received some, but I certainly didn't save those. I can't recall specifically. I have no records from there.
Q. What do you believe you would have received from Phillip Farrell?
MR. GROEDEL: Objection.
You may answer, if you can.
A. He is or was the Dean of the medical school. I am not sure what records he would have sent me. I don't

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

Q. What about Gordon Derzon?

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

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

MR. GROEDEL: Objection.

You may answer.

A. I can't recall receiving any.

Q. What about David Ward?

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

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

MR. GROEDEL: Object.

Q. -- and its conclusions?

MR. GROEDEL: Objection.

You may answer.

A. I can't recall.

Q. What about Dr. Scott Springman?

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

Q. What about documents from Lisa Brunette?
A. I don't know who Lisa Brunette is. Sorry.
Q. All right.
What about documents from UW Provost John Whiley?
A. Again, I don't have any recollection and I don't have any records.
Q. What about documents from Casey Nagy?
A. I don't have any records or a recollection of receiving anything.
Q. You will agree with me that an investigation was commenced relative to your time at University of Wisconsin Medical School involving yourself and medical records and billing practices, correct?
MR. GROEDEL: Objection.
You may answer.
A. Correct.
Q. And you will agree with me that as a result of that investigation, allegations were made that you saw patients, charted clinical findings and diagnoses, billed, but in fact did not examine the patients on the indicated dates; are you aware that substantively those were the allegations of that investigation?
MR. GROEDEL: Objection.
You may answer.
A. There were allegations of procedures occurring

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

Q. Why did --

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

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

A. Yes.

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

MR. GROEDEL: Objection.

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

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

MR. GROEDEL: Objection.

A. I can't recall the specifics.

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

MR. GROEDEL: Objection.

You may answer.

A. I can't recall.

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

MR. GROEDEL: Objection.

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

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

A. I can't recall.

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

A. Yes.

Q. And what was the name of counsel?

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

Q. Okay.

While you were at --

A. Michael Weiden.

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

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

Q. Were you involuntarily removed from the

chairmanship of that department?

MR. GROEDEL: Objection.

You may answer.

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

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

MR. GROEDEL: Objection.

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

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

pending claims that are directly relevant to that.

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

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

MR. MARGOLIS: Fair enough.

Could you please read back the last question.

(Record read.)

MR. GROEDEL: Objection.

If you know.

A. Allegations were made. Nothing was substantiated.

Q. All right.

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

MR. GROEDEL: Objection.

A. No, I did not.

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

A. Those should be in the chart.

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

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

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

Q. Okay.

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

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

Q. How would I determine that, sir?

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

Q. All right.

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

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

Q. And Doctor --

A. We had some Varian equipment.

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

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

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

Q. And we will get to that.

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

A. I think there is.

Q. All right.

Would it normally be in your office chart?

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

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

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

Q. All right.

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

A. Uh-huh.

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

A. That is the departmental chart.

Q. Okay.

Let me just quickly scan your CV.

Doctor, have you authored any articles on neuroblastoma?

A. No, I have not.

Q. When did you meet Dr. Wiersma?

A. In 1990.

Q. And you were married?

A. In 1993.

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

A. Yes.

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

A. Correct.

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

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

Q. Okay.

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

Q. All right.

Does Dr. Wiersma regularly refer patients to you

for radiation oncology evaluation and treatment?
A. Yes.
Q. Has Dr. Wiersma regularly referred patients to you, from '93 to present?
A. Yes.
Q. Approximately, can you tell me since the time that Dr. Wiersma -- did she start at UH at the same time you did, sir?
A. Started three years later. I started in '87 and Susan started in '90.
Q. All right.
MR. NORCHI: University of Wisconsin?
THE WITNESS: Yes, University of Wisconsin.
Q. (Continuing) My question is, at University Hospitals of Cleveland, when did you start?
A. I started in November of 1997 in an administrative role. My Ohio license was not issued until February or March of 1998, so that is when I would have started practice.
Q. When did Dr. Wiersma start?
A. I think in July of 1998.
Q. Can you give me any kind of idea of how many patients Dr. Wiersma would refer to you for evaluation and treatment on a yearly basis?
A. Ten or 15.

Q. Would you ever discuss your evaluation of the patients jointly with her?
A. Yes.
Q. All right.
I know there are consult notes that go back and forth.
A. Right.
Q. But given the fact that you are married, would you ever discuss what is going on with the patients outside of a professional setting?
A. We try not to.
Q. Does it happen?
A. It happens.
Q. If there are cases that are out of the ordinary for one reason or another, the two of you may discuss that out of the hospital on your personal time?
A. Yes.
Q. All right.
Has your medical license ever been revoked, suspended?
A. No.
Q. Has there ever been any disciplinary action taken against your medical license?
A. No.
Q. In any state?

A. No.
Q. The expert work that you did, did it involve issues of neuroblastoma?
A. Did not. No, it did not.
Q. Would you feel that Dr. Wiersma, based upon her education, skill and experience, has more experience in treating patients with neuroblastoma than you?
A. Yes.
Q. Would you defer to Dr. Wiersma on issues of prognosis for this disease?
A. Possibly.
Q. What is the caveat? Usually when I say, defer to my wife, I do it blankly. So what is the caveat here?
A. Well, again, I certainly know the disease process, so I could render an opinion that could be different than hers.
Q. Okay.
A. And certainly in other pediatric cancers that are common cancers, I clearly have much more experience than probably the majority of pediatric oncologists in the world, such as Ewing's sarcoma.
Q. Doctor, what medical records have you reviewed in preparation for this deposition?
A. I have reviewed the department of radiation oncology records.

Q. Which would be Exhibit 101?
A. Right.
I reviewed the pediatric -- pediatric oncology records. And this morning, for the first time, I saw the hospital records.
MR. GROEDEL: Portions of them.
A. (Continuing) Yes, I saw the -- right, the note I wrote on 1-26 I didn't know existed before.
Q. Doctor, what I have done to try to make it easier for us is I have bound exhibits that I will be making reference to during the course of this deposition, and at this point, counsel, this will be given to the court reporter.
I am asking you to look at the file marked Dr. Kinsella A, and I would ask you to please turn to Exhibit 19.
MR. WALTERS: What is this?
MR. MARGOLIS: This is the 5-31-2000 letter.
Do you have yours that you could like give back to them, so that they can --
MR. FINELLI: Yes.
MR. MARGOLIS: 19, Steve.
MR. WALTERS: Thank you.
MR. MORIARTY: With all of its attachments?

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

BY MR. MARGOLIS:

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

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

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

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

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

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

A. No, I have not.

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

A. No, I did not.

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

MR. GROEDEL: Objection.

You may answer.

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

Q. Do you know who authored Exhibit 19?
A. No, I do not.
Q. Doctor, do you remember when you were served with the lawsuit in this case?
A. I can't actually recall the date.
Q. Do you remember the month?
A. It was July of last year.
Q. That is probably right. It was filed July 11th, 2001.

Who did you speak with after you received a copy of the lawsuit, starting, if we can, first?
A. I actually didn't read it, I think, for up to a month, I didn't. And I think I talked to my wife, Susan, about it, since she was named.
Q. And you -- were you expecting to be sued in this case?
A. No.
Q. And you saw that you were named as a party defendant?
A. Right.
Q. And you did not read any portions of the lawsuit for approximately a month after you received it?
A. I think so.
Q. All right.

Did you turn it over to someone to handle on your

behalf?
A. No, I did not.
Q. Okay, so it sat on your desk for about a month, and then you decided it would be a good idea to review it?
A. I think Susan actually also received a copy, and I think she read it first.
Q. All right.
Did you speak with Dr. Shina about the lawsuit at any point in time from when you received it until present?
A. Once, about a month ago, after he was named.
Q. Tell me where that discussion occurred and what was said?
A. It occurred, I think, in the clinic. He said he was named along with Dr. Wessels and Dr. Beddar. And I was surprised, I didn't know why he would be named. And that was the conversation.
Q. Was anyone present when he had this discussion with you?
A. I don't think so.
Q. Did he initiate it, or did you?
A. He did, because he had been named.
Q. And he simply said to you, I have been named in this lawsuit along with these physicists?

A. Correct.
Q. And you said nothing?
A. Correct. I said -- well, I expressed surprise.
Q. Did Dr. Shina bring to your attention that Joshua was administered 1 Gray during his TBI as opposed to 10 Grays?
A. No.
Q. Did anyone bring to your attention at any point in time that Joshua was administered 1 Gray during his TBI instead of 10?
A. Not that I recall, no.
Q. If that information had been brought to your attention, i.e. that Joshua was administered 1 Gray instead of 10, what action would you have taken?
A. Oh, I would have notified the physicians involved, I think we would have notified the hospital, and they would notify the -- obviously the patient and/or the parents.
Q. So it is your testimony, Dr. Kinsella, that at no point in time before this lawsuit being filed were you ever advised by anybody that this patient had received 1 Gray of TBI instead of 10?
A. Yes, correct.
Q. Dr. Kodish, did you have any discussions with him relative to the lawsuit?

A. No, I did not.
Q. Dr. Shurin?
A. I had a discussion with Dr. Shurin, I think in -- I would guess in September of 2001, or it could have been October, that she brought it up that she was aware, and I said I made a mistake in the prescription, and it was a brief conversation. She related a time when she had made a mistake in a prescription, and basically said, you know, things like that can happen. It was a very brief discussion.
Q. What about Barb Scott?
A. No.
Q. Sam Beddar?
A. No.
Q. Barbara Gleason?
A. No.
Q. Dr. Kitchen?
A. No.
Q. Dr. Wiersma?
A. Not -- I mean, obviously after the suit, we were aware of it, I certainly talked to her about it.
Q. David Abrams [sic]?
A. No.
Q. Barry Wessels?
A. No.

Q. Diane Otto?
A. No.
Q. You told me that you started at UH in November of '97 and you started your clinical work February of '98. Give me --
A. Or March, I can't recall.
Go ahead.
Q. All right.
Give me an idea of what your duties and responsibilities are at Case -- or at UH? You are the chairman of the department?
A. Correct.
Q. And chairman of what, the department of radiation oncology?
A. Radiation oncology, yes.
Q. All right.
And does that attendant responsibility have certain administrative duties?
A. Yes.
Q. And how much of your time is involved in administrative duties?
A. I probably spend 20 percent of my time in administration.
Q. And what do the administrative duties involve?
A. I am the director of radiation oncology in the

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

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

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

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

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

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

A. Right.

Q. Okay.

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

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

Community, the Community Health Partners.

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

A. That is correct.

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

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

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

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

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

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

Q. You admit that the radiation dose of 1 Gray to Joshua Valdivieso instead of 10 was a mistake?
A. Yes, I do.
Q. And you admit that giving him 1 Gray of radiation for the circumstances that you were providing that treatment was a breach of the standard of care?
MR. GROEDEL: Objection.
You may answer.
A. Well, the intended dose was 10 Gray. So yes.
Q. All right.
Doctor, I want you to educate me now on the protocols, the documents that would be generated, the paper trail and the people involved in treating Joshua for total body irradiation under the circumstances that he was.
First, would a physicist be involved?
A. Yes.
Q. Would a dosimetrist be involved?
A. Yes.
Q. Would a radiation technologist be involved?
A. Right, yes.
Q. Usually would a referring oncologist be involved?
A. Not in the delivery.
Q. No. I am saying, from the inception --
A. Yes, yes.

Q. -- through the conclusion.
A. Yes.
Q. All right.
And then there would be a consultation by the radiation oncologist?
A. Correct.
Q. Would there be anesthesia involved?
A. Yes. In someone Joshua's age, yes. Not for adults.
Q. Would there be nurses involved?
A. Yes.
Q. All right.
What I would like you to do is to tell me what the role is of the physicist in these circumstances?
A. The physicist supervises the machine calibration, the setup and the delivery of the radiation.
Q. Okay.
And what duties does the physicist execute to accomplish those goals, the calibration and the delivery of the radiation? In other words, you are the radiation oncologist.
A. Right.
Q. You make a determination of what is the dose that you want the patient to receive, correct?
A. Uh-huh, uh-huh. Yes.

Q. And walk me through, when does the physicist get involved in the process?
A. Shall we use the specifics of Joshua?
Q. Yes, sir.
A. Well, if I can have the chart, I can -- I don't have all the dates.
Q. You may want to look at Exhibit -- they are all in there, I believe, and certainly refresh your recollection with 101, but I would like you to go through Exhibit A, Doc, and if you could find the corresponding record, it would be easier for me to follow.
A. So I first met Joshua, the patient, and his mother on the 6th of January of 2000.
Q. Can you tell me what document you are looking at, sir?
A. I am looking at Document 6.
Q. Thank you.
And that would be the first time that you had any involvement with Joshua Valdivieso?
A. Correct.
Q. And that was at the referral of Dr. Wiersma?
A. Correct.
Q. Okay.
A. And that is what it says, this is the initial consultation, it is a four page document where I review

the history of the patient's presentation of disease.
Q. Uh-huh.
A. The review of systems that I obtained through the mother.
Q. Uh-huh.
A. The past medical history that principally came from the patient's mother.
Q. Uh-huh.
A. The social history, again obtained principally from the mother, the family history, and then the physical examination.
Q. Okay.
And the reason that you were seeing Joshua in January of 2000 was to determine whether or not he was an appropriate candidate for consolidative irradiation as part of his CCG protocol for treatment of Stage IV neuroblastoma; is that correct?
A. Correct, yes.
Q. And if you determined at that point in time that you did not believe total body irradiation would be beneficial for him, it was certainly your judgment to say, I don't think this treatment has the potential to help this child, correct?
A. I was -- the question I was asked at that time and the reason for the consultation was to look at local

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

Q. Let me take the dive this way:

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

A. Correct.

Q. All right.

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

A. Correct.

Q. All right.

So you saw Joshua on January 6th.

A. Right.

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

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

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

Q. All right.

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

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

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

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

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

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

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

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

A. Correct.

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

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

Q. The tumor board?

A. Correct.

Q. Okay.

What is the purpose of the tumor board, sir?

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

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

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

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

A. I think --

MR. GROEDEL: Objection.

You may answer.

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

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

A. I don't see the minutes.

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

A. I don't know.

Q. Okay.

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

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

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

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

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

A. Correct.

Q. All right.

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

Q. All right.

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

Q. Okay.

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

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

A. Correct.

Q. All right.

And you concurred in that?

A. Yes, I did.

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

A. Yes.

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

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

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

Q. Can you show me where that note is?

A. That is Number 4.

Q. Okay, uh-huh.

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

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

THE WITNESS: Okay. It is hard.

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

MR. MARGOLIS: Yes, please.

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

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

A. Exactly.

Q. Okay.

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

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

A. Probably 350, 400.

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

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

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

A. Yes.

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

A. No.

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

patient?
A. During the treatment, it is a -- well, it is a sequential interaction.
Q. Okay, but it is done as a team, to treat the patient?
A. Not the same team.
Q. Not the same team, but in generality, I am talking the physicist --
A. Right.
Q. -- the radiation techs, the dosimetrists, they are all part of the team that is rendering care to the patient?
A. Yes.
Q. Okay.
And I understand that they may not all be providing care simultaneously, as what happens during an operative procedure.
A. But there is not a TBI team, per se.
Q. I understand that. I am using team --
A. Right, right.
Q. -- to indicate it is a collective --
A. A group of people.
Q. And you would agree with me that the physicists have independent responsibilities and duties to the patient in the rendering of TBI care?

A. Yes.
Q. You would agree with me that the radiation technologists have independent responsibilities and duty to a patient receiving TBI care?
A. Yes.
Q. You would agree with me that the nurses have various responsibilities and duties to a patient receiving TBI?
A. Yes.
Q. Is there a system of checks and balances that is designed into the system where TBI is given to a patient?
MR. GROEDEL: Objection. It seems sort of vague, the question.
Q. (Continuing) Do you understand what I meant?
MR. GROEDEL: Are you talking about the dosing checks and balances?
A. Is there a written procedure? I don't know of any.
Q. Let me ask you in generality, in a patient that is being administered TBI, are there any checks and balances inherent in the system relative to that care --
MR. GROEDEL: Objection.
Q. -- at UH, in January of 2000?
MR. GROEDEL: You may answer.
Objection.

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

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

(Pause)

THE VIDEOGRAPHER: Straighten out your mike.

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

THE VIDEOGRAPHER: That is good. Thank you.

BY MR. MARGOLIS:

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

MR. GROEDEL: Objection.

You may answer.

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

Q. Okay.

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

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

Q. All right.

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

A. There wasn't.
Q. At University Hospitals?
A. Right.
Q. In January of 2000?
A. Right.
Q. Didn't you have to sign off on various physics computation sheets?
A. No.
Q. Was there any type of checks and balances inherent in the system of TBI at facilities other than RB&C in January of 2000 --

MR. GROEDEL: Object.

Q. -- based upon your knowledge?

MR. GROEDEL: Objection.

You may answer.

A. I don't know.
Q. Doctor, you are a nationally renowned expert in your area of specialization, are you not?
A. Yes.
Q. All right.

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

A. Yes, I do.
Q. You have designed radiation oncology programs in the course of your career, correct?

A. Yes, I have.
Q. You are knowledgeable generally about what it is that is done in the, quote unquote, medical specialty of radiation oncology relative to the systems used for administering TBI treatment to a patient, correct?
A. Correct.
Q. In any institution that you are aware of, were there checks and balances that were designed into the system relative to the dosing of a patient for TBI?
MR. GROEDEL: Objection.
You may answer.
A. In reviewing what existed in January of 2000, I am aware of, that the system was not fail-safe, obviously.
Q. I am not asking you, sir, the specific system at UH. I am asking you in generality, given the fact that you have testified of your level of expertise in this area, both at UH and what was done in the, quote unquote, community of radiation oncology, would a checks and balance system be something that would exist in other facilities, albeit not UH?
MR. GROEDEL: Objection.
If you know.
Q. (Continuing) That you know of?
A. Well, a system existed at UH, but it wasn't fail-safe.

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

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

A. Because --

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

A. Okay.

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

A. Correct.

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

A. 2000.

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

MR. GROEDEL: Objection.

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

Q. (Continuing) Quality control.

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

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

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

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

Q. Would you please turn to Exhibit 15.

A. (Witness complies).

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

MR. MARGOLIS: We can do it right now.

MR. MORIARTY: If this is convenient.

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

(Short recess had.)

BY MR. MARGOLIS:

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

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

A. Okay.

Q. Okay.

A. So we are not referencing 16 any more?

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

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

Q. 4?

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

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

Q. Do you know who that person was?

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

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

Q. Okay.

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

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

Q. Okay.

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

Q. All right.

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

Q. Would this basically be --

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

Q. Okay.

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

Q. All right.

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

A. No, no.

Q. Okay.

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

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

Q. Okay.

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

Q. Okay.

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

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

Q. Was she at all involved?

A. During his TBI --

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

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

Q. Okay.

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

doing a lot of things that day, so I am not sure.
Q. Would she accompany the patient when the TBI was being administered? Certainly not in the room at the time it was being administered, but --
A. May or may not. It depends on the schedule, if they are early or late. Our clinics run from around 7:00 in the morning to, at that time, probably 6:30 or 7:00 o'clock at night, so the nursing hours were often staggered, so I don't know.
Q. Would she document any progress notes relative to any care she had of the patient?
A. No.
Q. Would the radiation techs document any records relative to the job they have in the TBI?
A. Yes, and that is documented in the chart, which is listed Number 13 and 14.
Q. Okay, let me look at that, sir.
So 13 would be a document generated by the radiation technologist?
A. Correct, 13 and 14, it is the same document, it is just the other side of the page.
Q. Would they provide any other documentation in addition to what is set forth in 13 and 14?
A. No.
Q. And would 13 and 14 be made contemporaneous with

the administering of the TBI --
A. Yes.
Q. -- by the radiation technologist?
A. Correct.
Q. Do we know who the radiation techs were by looking at 13 and 14?
A. Yes, they initial.
Q. Where is it on 13, sir?
A. Therapists Initials, it is on 14.
Q. Okay, 14. All right.
And who would the therapists have been?
A. BS would be Barb Scott and DO would be Diane Otto.
Q. All right, now what about the box that says M.D. Initials?
A. Again, that is something that I, personally, never signed on any patient.
Q. What is it for?
A. I am not sure.
Q. So would it be that the M.D. would come down and oversee the administration of TBI and then sign off?
MR. GROEDEL: Objection.
You may answer.
A. This is a standard form for all of our patients. But again, in the four years I have been treating, I can't recall ever signing that in that column. I put

notes in the chart.

Q. Do you know what its purpose is?

A. No, I do not.

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

MR. GROEDEL: Objection, asked and answered.

Go ahead.

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

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

MR. WALTERS: He just told you.

MR. GROEDEL: He told you.

MR. MARGOLIS: I am sorry.

MR. GROEDEL: Yes, he did.

Q. (Continuing) What about the physicists? You don't need this, do you, Doctor (indicating)?

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

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

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

Q. What is Number 15, Doctor?
A. The 15 is actually the calculation, it is listed 18 MV X-rays Total Body Irradiation Calculation Sheet, and it says, Use Spoiler Factor, this is the standard, this is the checks and balances you were asking about, these are some of the checks and balances.
Q. Would 15 be generated by the prescription?
A. Yes.
Q. All right.
Now, where it says, calculated by, would that be David Abrams [sic]?
A. DA, I assume that is his initials.
Q. And where it says, checked --
A. Right.
Q. -- who is that?
A. SAB would be Dr. Beddar.
Q. Who is -- and he is a physicist?
A. Physicist, yes.
Q. Sam Beddar?
A. Yes, Sam Beddar.
Q. Is he employed by Case?
MR. GROEDEL: Objection.
You may answer, if you know.
A. Yes, he is, but he is paid by University Hospitals of Cleveland.

Q. All right.

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

MR. GROEDEL: Objection.

You may answer.

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

Q. Okay.

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

A. Because that is what physicists do.

Q. Okay.

And would Mr. Beddar --

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

Q. Okay.

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

A. Right.

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

A. Yes.

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

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

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

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

A. I do not know.

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

A. I do not know.

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

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

Q. Was this a simulation?

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

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

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

Q. Okay.
A. But they are both dated the same day, so --
Q. Doctor, did Dr. Beddar ever discuss with you the dose of 1 Gray?
A. No, he did not.
Q. Would you expect a physicist discharging the duties that Dr. Beddar was discharging in the care of Joshua Valdivieso to bring to the attention of the prescribing radiation oncologist a subtherapeutic dose?
MR. GROEDEL: Objection.
You may answer.
MR. WALTERS: Objection.
A. I would have wished he questioned that. Doses in the range of 1 Gray have been given before.
Q. For patients with the medical profile and goals that Joshua was being administered TBI?
A. No.
Q. Okay.
A. But pediatric and adult patients, in some pediatric malignancies.
Q. My question is this:
Has there ever been a dosage of 1 Gray for TBI under the circumstances of the patient profile of Joshua's?
A. Not that I can recall.

Q. All right.

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

MR. GROEDEL: Objection, asked and answered.

MR. WALTERS: Objection.

MR. NORCHI: Objection.

MR. GROEDEL: Asked and answered. Go ahead.

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

A. But I wrote the prescription.

Q. I am not asking that.

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

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

MR. GROEDEL: Objection.

MR. WALTERS: Objection.

MR. GROEDEL: You may answer.

MR. NORCHI: Objection.

A. Possibly.

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

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

Q. You --

A. And he carried out the prescription.

Q. Okay.

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

MR. GROEDEL: Objection, asked and answered.

MR. WALTERS: Same objection.

MR. NORCHI: Objection.

A. Maybe. I am not sure. Yes.

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

MR. GROEDEL: Objection. If you --

A. I am not sure.

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

A. Technically, yes.

Q. All right.

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

MR. GROEDEL: Objection.

You may answer.

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

(Record read.)

MR. MORIARTY: Thank you. Sorry.

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

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

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

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

A. No.

Q. -- prior to TBI being administered?

A. No, I did not.

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

A. No.

Q. All right.

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

A. Yes.

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

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

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

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

Q. All right.

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

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

A. Correct.

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

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

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

A. No.

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

A. Yes.

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

A. Yes.

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

A. Correct.

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

A. No.

Q. What is the name of the piece of equipment that clicks every time a dosage of administration is -- a dosage of radiation is administered?
A. Well, there is a control panel for the linear accelerator that is programmed with the dose as part of that.
Q. Is there some audible sound that is made?
A. No.
Q. Do you know what the time would be for a dosage of 1 Gray that is fractionated?
A. The prescription was written to go to a dose rate of 5 to 10 centiGray a minute. I think this machine, with these calculations, typically delivers it around 7.5 centiGray a minute. So a hundred centiGray would be about 14 minutes.
Q. And that would be at what total dose?
A. At a hundred, as I said.
Q. My question is, if this child had received 10 Grays, how long would it have taken to administer the treatment on a daily basis?
A. About 45 minutes or longer each day.
Q. And based upon the prescription of 1 Gray, how long would it take on a daily basis, 14 minutes?
A. Substantially, yes.
Q. Would you expect that to be something to be picked

up by a radiation technologist?

MR. GROEDEL: Objection.

You may answer.

MR. WALTERS: Objection.

A. They were carrying out the prescription.

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

A. No.

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

MR. GROEDEL: Objection.

You may answer.

MR. WALTERS: Objection.

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

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

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

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

A. No.
Q. Were there any radiation records that you removed from this chart at any point in time?
A. No.
Q. When a patient is being treated for TBI, do you evaluate the patient at all --
A. Yes.
Q. -- on the dates of treatment?
A. Typically on the first and last day, if it is twice daily. In this case, it was just on the first day.
Q. So you evaluated Joshua on 1-26 before or after his TBI?
A. I think it is probably afterwards, because I comment he tolerated it.
Q. Where is your note of seeing him on 1-26?
A. It is in the hospital record.
Q. Okay, can you show that to me?

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

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

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

26th?

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

Q. Okay.

And do you recall what the note indicated?

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

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

MR. GROEDEL: No.

MR. MARGOLIS: I need it.

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

Is this it?

THE WITNESS: Uh-huh.

MR. GROEDEL: This is it.

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

BY MR. MARGOLIS:

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

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

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

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

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

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

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

A. I can't recall.

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

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

Q. Okay.

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

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

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

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

Q. Okay.

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

determine that there was an error in dosing, correct?
A. Correct.
Q. Now, Doctor, would you please pull out for me -- tell me this:
Did you see him on any date other than 1-26 after TBI, either 1-27, 1-28?
A. I can't recall.
Q. If you would have, do you believe you would have written a note?
A. Not necessarily, unless there was a change.
Q. Okay.
Now, please show me, from Exhibit 101, the prescription for Joshua's TBI?
A. It is the top line (indicating).
MR. MARGOLIS: Doctor, why is it, after Joshua's -- you know what? Let me get back to that on clean-up, all right?
Marc, I don't know how you want to do it. I want to mark this, to make reference to it, but I don't know if you want me to put it on the original, or how --
MR. GROEDEL: Why don't you put it on the back of it.
MR. MARGOLIS: Fine.

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

BY MR. MARGOLIS:

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

A. This is the prescription.

Q. For Joshua's TBI?

A. Right, as well as his subsequent treatments.

Q. And that is written in your hand?

A. Yes.

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

A. Yes.

Q. Read it for me?

MR. GROEDEL: Read what?

MR. MARGOLIS: The writing that is not his.

A. I think the 18X.

Q. Where is it?

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

Q. Who wrote 18X?

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

Q. All right.

And is all of the other writing yours, other than

18X?

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

Q. Okay.

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

A. Yes, 1 Gy, yes.

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

A. Yes.

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

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

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

MR. GROEDEL: Objection.

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

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

assurance/peer review and therefore is privileged from discovery.

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

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

MR. GROEDEL: Right.

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

MR. GROEDEL: I understand.

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

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

MR. MARGOLIS: Okay, and just --

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

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

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

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

BY MR. MARGOLIS:

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

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

A. I am not sure.

Q. Okay.

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

A. No, I do not.

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

recall whether you did or whether you did not?
A. That is correct.
Q. Do you know how many changes were made in that box?
A. No, I do not.
MR. MARGOLIS: May I see that original, please.
(Thereupon, the document was handed to Mr. Margolis.)
MR. MARGOLIS: And in going forward, it should not be construed as a waiver for me to redepose the witness on these issues after the court rules.
BY MR. MARGOLIS:
Q. Do you always use a black pen?
A. No.
Q. In looking at the alterations that are set forth on Exhibit 102, in the top box of Total Dose (Gy), does that appear to you to be your handwriting?
A. I can't tell.
Q. You indicated to me that that may have been you that made the change, but thereafter it would have been brought to your attention that that was not something that should be done?
MR. GROEDEL: Objection.

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

MR. MARGOLIS: Sure.

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

MR. GROEDEL: Objection.

You can answer.

Q. (Continuing) Is that --

A. Correct.

Q. Okay.

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

MR. GROEDEL: Objection.

You can answer.

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

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

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

lawsuit in this case was filed?
A. Right.
Q. So there would be no way, if you made this alteration, that it would have been apparent in the medical record chart prior to July of 2001?
A. This -- right, this meeting was after 2000 -- July of 2001.
Q. And no one brought to your attention that there was a mistaken dose given to Joshua as part of his TBI before the lawsuit was filed?
A. I do not recall. No one brought it to my attention.
Q. And again, are you saying that it may have been brought to your attention but you do not recall, or it was not brought to your attention?
A. I do not recall it brought to my attention. I don't remember.
Q. Are you aware of anybody else who would have made the alterations on Exhibit 102?
A. I mean, this is a department record. Anyone in the department could have, potentially.
Q. Do you know why anyone would have?
A. I do not. Possibly whoever wrote the anonymous letter.
Q. So you are saying that someone may have had an

intention of framing you?

MR. GROEDEL: Objection.

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

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

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

A. I don't know of any.

Q. Okay.

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

A. I am not sure.

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

A. Uh-huh.

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

MR. GROEDEL: Objection.

You may answer.

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

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

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

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

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

A. No.

MR. GROEDEL: Objection, asked and answered.

A. (Continuing) No.

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

A. Right, correct.

Q. Would you please turn to Page 1?

A. In this (indicating)?

Q. Yes.

A. Okay.

Q. Is all this your writing?

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

Q. Okay, the 1 Gray is yours?

A. The 1 Gray is mine.

MR. GROEDEL: The circle?

THE WITNESS: I have no idea.

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

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

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

BY MR. MARGOLIS:

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

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

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

A. That was the intent.

Q. Okay.

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

Q. All right.

And then when was the prescription changed?

A. On the 18th.

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

A. Right.

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

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

Q. How do you know that?

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

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

A. It is on Number 5, okay?

Q. Where are we at, 5-18?

A. 5-18.

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

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

A. Right.

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

Q. Okay.
A. So the total dose I wanted to deliver is 35 Gray to this boost volume.
Q. Okay.
A. So I changed the prescription from the 10th, because he didn't indeed receive 35 Gray. It is updated on the prescription from the 18th that he received only 7 of those intended 14 treatments, or he received only 17.5 of the intended 35 Gray.

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

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

MR. GROEDEL: Do you understand the question?

THE WITNESS: No.

MR. MARGOLIS: Would you read it back.

(Record read.)

A. Yes, that would be a standard policy.
Q. Okay.

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

the way it was? Because it had already been administered.
A. No, it hadn't.
Q. Okay, maybe that is where I am missing you.
A. Right, right.
So on the 10th --
Q. Well, on the 18th, Doctor, is when you changed the prescription, correct?
A. Right.
Q. And on the 10th, what did he receive?
A. Between the 10th and the 18th, he received 17.5 Gray.
Q. Okay.
A. So on the 10th, he received 2.5 Gray, and I am not sure what day of the week it is, but --
Q. Okay.
A. -- you can go back, and then the next -- until he got -- he got seven treatments between the 10th and the 18th.
Q. Okay.
A. So then he has another MRI scan, we say, we don't have to treat the entire brain, he has got bone metastases, so we modify the field and modify the prescription because we didn't -- what we wrote on the 10th, indeed by the 18th we had modified, and then we wrote a new prescription.

Q. Okay.

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

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

MR. MARGOLIS: Sure.

Could you please reread that.

(Record read.)

BY MR. MARGOLIS:

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

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

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

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

A. That is right.

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

A. Right.

Q. Okay.

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

A. I do not.

Q. Okay.

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

A. Uh-huh, dose per fraction.

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

A. Right.

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

A. Right.

Q. Okay.

Do you know how many times that was altered?

A. No.

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

MR. GROEDEL: Objection.

You may answer.

A. Any intentional alteration, yes.

Q. How do you find the word -- define intent?
A. That I purposefully changed it to hide something, how is that?
Q. Okay.
Is a negligent alteration violative of the guidelines of UH?
MR. GROEDEL: Objection.
You may answer.
A. I don't know.
MR. MORIARTY: May I see that original for one moment, please?
(Thereupon, the document was handed to Mr. Moriarty.)
MR. MORIARTY: Off the record for a second.
THE VIDEOGRAPHER: Off the record.
(Thereupon, a discussion was had off the record.)
BY MR. MARGOLIS:
Q. What is the protocol, if you determined that there has been an error made in the dosing of a patient such as these circumstances?
A. It generates a report called a dose discrepancy form, or something like that, that is outlined, and the details are briefly summarized, and it is signed by the physician and reviewed by quality assurance.

Q. Did you ever represent to the tumor board that you gave Joshua 10 Grays when you knew you had not?
A. No. I always thought I had given him 10 Gray in the tumor boards.
Q. Was a dose description form or discrepancy form generated based upon the treatment you provided to Joshua?
MR. GROEDEL: Objection.
You may answer.
A. I don't know of any.
Q. Why wouldn't you have done so after you learned that there was an error?
A. I learned of the error after July of 2001, and I am not sure what the purpose of that would be.
Q. What duties do you owe the family of a patient under these circumstances?
A. Well, I certainly will apologize when I see them, but I wasn't sure if it was appropriate at this point, when I learned of this, over a year after his death --
Q. Had you learned --
A. -- that I would, you know -- you know, I am not sure if that is appropriate for a physician, at this point, when a suit has been made, to interface with a family.
Q. Had this been brought to your attention earlier,

what would you have done?
A. I would have met with the family, I would have notified the pediatric oncologist and met with the family.
Q. And the first time you would have informed Dr. Wiersma of this mistaken dose on your behalf was when?
A. It was when we reviewed the chart after the lawsuit.
Q. At any point in time in your treatment of Joshua, did you tell the family that you were a physician operating independent of University Hospitals?
A. No. I have my name tag on all the time, it says University Hospitals of Cleveland, and describes me.
Q. Who was your employer in 1999 and 2000?
A. Technically it is University Radiation Medicine Associates.
Q. At all times you treated Joshua, it was on the campus of University Hospitals?
A. Yes. That is the only place I treat patients.
Q. Do you have any independent recollection of Joshua?
A. No, I do not.
Q. Would you agree with me that as a result of the 1 Gray being administered, that Joshua was denied any

opportunity of the benefit of TBI?

MR. GROEDEL: Objection.

You may answer.

A. No.

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

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

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

A. Would it have changed his outcome? No.

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

Would you read the question back to Dr. Kinsella.

(Record read.)

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

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

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

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

being administered TBI.
A. Uh-huh.
Q. It was to hopefully have him go into a period of remission and increase his time of survival, but not an ultimate cure?
A. That is correct.
Q. Based upon him receiving 1 Gray as opposed to 10, was the intent of him receiving TBI thwarted?
A. No.
Q. Then why do it at all?
A. Well, I think that it is not common -- it is not a standard of care today, and it was an attempt to delay time to recurrence, but total body irradiation is a very small part of his overall treatment.
Q. Okay, we are talking --
A. His overall treatment wasn't working.
Q. We are talking about what the standard of care was in 2000, are we not?
A. Correct.
Q. All right.
And it is your testimony today under oath that the intent of this child receiving TBI was not adversely affected as a result of him being administered 1 Gray versus 10; is that correct?
A. In Joshua's case, yes.

Q. Okay.
A. Again, the intent was to give the 10 Gray, but I don't think that it --
Q. But it made no difference?
A. I don't -- in my heart of hearts, no, unfortunately not.
Q. But in 2000 when it was administered, you were hoping it would?
A. The repeat restaging by the MIBG and the MRI scan that were done, I think, on the 6th and the 7th and the 10th were pretty humbling in terms of assessing his chances with anything we had.
Q. Doctor, did you expect this child to have the potential of benefiting from TBI when it was administered in January of 2000?
A. Yes.
Q. Okay.
And point in fact, it was represented to the parents of this child that TBI would hopefully be of some benefit to him, and that is why it was being administered in January of 2000, correct?
A. Correct, correct.
Q. And in your opinion, the fact that there was a change in a subtherapeutic dose did not in any way negatively impact the intent of TBI being administered?

A. It may have negatively a little, but it didn't mean the difference between cure or prolonged survival.
Q. Okay.
Do you think he would have died of the causes that he did in June of 2000 had a therapeutic dose been administered?
A. It would be speculation. If not June, it would have been July or August.
Q. What chance of survival do you believe Joshua had for cure?
MR. GROEDEL: At what point?
MR. MARGOLIS: January of 2000.
A. After the restaging? We certainly put it at less than five percent, and probably realistically zero.
Q. When did the restaging occur?
A. On the 6th and the 10th of January.
Q. Okay.
A. Part of it. There may have been more.
Q. Have you destroyed any medical records in this case?
A. I have not.
Q. At any point in time, have you gone to the medical records department to review medical records in this case?
A. No, I have not.

Q. So you have never gone to the medical records department to obtain Joshua Valdivieso's medical chart?
A. No, I have not.
Q. When you go to the medical records department, do you have to sign the chart out?
A. To be honest, I have never been to the medical records department.
Q. Have you asked that Joshua's chart, hospital chart, ever be brought to your office?
A. No. The first time I saw the chart was earlier this morning.
Q. If you make a mistake in a medical record -- this has happened to you in the past, has it not? I mean, if a mistake is made in a medical record, isn't there a specific procedure that is to be followed?
A. Usually date it and record what was done.
Q. And do you put error -- or cross it out and write error, and then write in what is correct?
A. That can be the case.
Q. And you would have had occasion to do that prior to July of 2001?
A. In what, though?
Q. In a medical record.
A. Say those dose administrations that we talked about, if there is a misadministration, we will then go

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

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

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

Q. Okay.

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

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

A. Correct.

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

MR. GROEDEL: Objection.

You may answer.

A. Correct.

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

27th, 28th?
A. We have a billing agency that does that.
Q. Do you generate any records that they review?
A. No.
Q. Who does?
A. There is a billing specialist.
Q. Who are they?
A. It is Walt Blackam. It is a company that we still use.
Q. Have you ever been sued for malpractice before this?
A. No, I have not.
Q. Do you have any enemies in the department that you can think of that would write Exhibit 19?
MR. GROEDEL: Objection.
You may answer.
Q. (Continuing) The reason I ask that is that you had indicated that whoever wrote that may have modified the chart.
A. Not that I am aware of.
Q. Have there been any complaints that have been made against you during your period at University Hospitals?
A. None that --
MR. GROEDEL: Objection.
Q. Either by residents or other staff?

A. None that have been brought to my attention.
Q. Do you believe that Josh's period of event free recurrence would have been at all altered had he received a therapeutic dose of TBI, based upon what you knew in 2000?
A. I am not sure.
Q. Had the therapeutic dose of TBI been administered to Joshua in January of 2000, would he have developed the skull metastasis that he presented with in May of 2000?
MR. GROEDEL: Objection.
A. I am not sure.
Q. Doctor, would you go to this category, B.
A. Do you want this back, or where does this go?
MR. MARGOLIS: You can just give that to the court reporter.
MR. MORIARTY: Unless you are pretty close, within moments of being done --
MR. FINELLI: We are not.
MR. MORIARTY: When you get to the next breaking point, let's take a break.
MR. MARGOLIS: We can take a break right now.
THE VIDEOGRAPHER: Off the record. End of Tape 1.
(Short recess had.)

BY MR. MARGOLIS:

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

A. (Witness complies).

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

A. It was in my office.

Q. How many people other than yourself were present?

A. Two others.

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

A. No.

Q. Were they employees of University Hospital?

MR. GROEDEL: Objection.

You may answer.

A. One was.

Q. Who was the other?

A. A physician.

Q. Was it Dr. Wiersma?

MR. GROEDEL: Objection.

You may answer.

A. Yes.

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

records at that meeting?
A. No, I haven't.
Q. It is nothing that the two of you have discussed?
A. No.
Q. Okay.
You referred to the TBI dose sheet when you treated the patient on 5-10 and 5-18, correct?
A. I don't understand the question.
Q. This TBI dosage sheet which we have marked on the back as Exhibit 102 --
A. Right, yes, correct.
Q. -- that is an ongoing sheet, correct?
A. Correct.
Q. It is the same sheet that you utilized for his prescription for the TBI on 1-17, correct?
A. Correct, yes.
Q. So whatever notations would have been on the sheet on 1-17 would have been present when you reviewed the sheet again to write the 5-10 dosage, correct?
A. Correct.
Q. And whatever notations would have been on the sheet on 1-17 would have been present when you reviewed the sheet for the 5-18 dosage, correct?
A. Correct.
Q. Why didn't you see, on 5-10, that he was given 1

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

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

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

A. That is correct.

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

A. If I saw it, yes.

Q. Okay.

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

A. Correct.

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

A. Correct.

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

MR. GROEDEL: Objection.

You may answer.

A. I don't know.

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

A. No.

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

Q. Doctor, let me be nauseatingly clear.

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

MR. GROEDEL: Objection.

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

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

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

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

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

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

A. I did not.

Q. All right.

Do you know if these two people who were in the

room actually saw you alter it, if you did?
A. One of the persons said, don't mark that chart, keep that pen away.
Q. Before or after you -- before or after the alteration?
A. I can't recall. It was a person I was explaining what happened, or what I thought happened, in terms of writing the wrong dose.
Q. It presumably would not have been Dr. Wiersma who said, don't alter that, keep your pen away, it would have been the other individual?
A. That is correct.
Q. The chart that is on the front, Doctor, what is it marked, please, the exhibit number on the front; is it 100 on the front of that?
A. Of the whole thing?
Q. Yes.
A. 101.
Q. 101.
Where is that chart normally kept in the regular course of business?
A. Since he died, we send them out to some contractor.
Q. Before his death?
A. Down in the department.

Q. Of radiation --
A. Radiation oncology, correct.
Q. At some point in time, have you caused that chart that is marked 100 -- is it 101?
A. 101.
Q. -- to be in your office under lock and key?
A. Since I met with Marc Groedel in February of 2002, he requested I keep the chart.
Q. All right.
I am going to request that the chart remain in the offices of Reminger & Reminger and --
A. Sure.
Q. -- be under the custody of Mr. Groedel --
A. Where it has been since whenever you requested it. I mean, I haven't had it recently. I don't know when I sent it down there. It was a couple -- several weeks ago.
Q. So the original chart has been here for several weeks?
A. Yes.
MR. GROEDEL: A week or two.
THE WITNESS: Well, whenever, yes.
Somebody from your office picked it up.
MR. GROEDEL: We will agree to keep it.
MR. MARGOLIS: Thank you.

BY MR. MARGOLIS:

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

A. Uh-huh, I am there.

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

A. Yes.

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

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

Q. Okay.

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

A. Correct.

Q. -- to TBI?

A. Correct.

Q. Would you have expected -- strike that.

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

Would you please turn to Page 32.

MR. WALTERS: Can I get a clarification? Are we now on something that you are going to be designating as an Exhibit B, or --

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

MR. WALTERS: Okay.

MR. MARGOLIS: And then --

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

MR. MARGOLIS: Yes, sir.

MR. WALTERS: All right.

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

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

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

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

A. That is right.

Q. Is that your signature?

A. Yes, it is. It is --

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

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

Q. Okay, but you signed off --

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

different times.
Q. Why is it different for TBI?
A. We detected a flaw after -- as a consequence of this.
Q. Was that a flaw that was systemic just to UH --
MR. GROEDEL: Objection.
Q. -- or is that the way the community of radiation oncology operates?
MR. GROEDEL: Objection.
You may answer.
A. I don't know.
Q. Would you please go to 33.
A. (Witness complies).
Q. What is this?
A. This is the calculations for that brain boost that was prescribed on the 18th, and this is being done on the 19th.
Q. And who were the folks -- it says, Calculated by J. Wright. Who is Checked by?
A. That is a good question. It must be a physicist, but I can't recognize the writing.
Q. Okay.
When did you say he had another restaging in January?
A. I would have to look at the records, but my

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

Q. Okay.

A. -- of January, 2000.

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

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

Q. Okay.

And did you have meetings with anybody from UH?

MR. NORCHI: Objection.

MR. GROEDEL: You may answer.

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

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

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

Q. Well, that is what I --

A. Okay.

Q. Okay, maybe that is different --

A. Right, it is.

Q. -- than the actual --

A. It is different.

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

A. Right.
Q. -- predicated on being credentialed.
A. And accepted.
Q. And accepted.
Who was -- who recruited you?
A. There was a search committee that was established by both the Dean and the CEO of the hospital.
Q. Can you give me names?
A. Jim Willson, who is the head of the Ireland Cancer Center, was the chair of the search committee. The other members would have been, I think, Robert Ratcheson, who is the head of neurosurgery; Marty Resnick, I think was on the committee, who was the head chairman of urology; and the chairman of neurosurgery. I think Tom Stellato was on it, who is the division head of general surgery in the department of surgery. I think someone from the department, I think it was from the -- well, they were forming a new department, so it didn't exist, but I think it was Nancy Oleinick, who is a Ph.D. radiation biologist. I am pretty sure that is it.
Q. Okay.
After you met them and they met you and the decision was made that they wanted to extend an offer to you --
A. Well, I then would have interviewed extensively

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

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

A. Correct.

Q. What did that entail?

MR. NORCHI: Objection.

MR. GROEDEL: You may answer.

MR. WALTERS: Objection.

MR. GROEDEL: I will object.

You can answer.

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

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

A. They were aware of it.

Q. Okay.

How were they aware of that, sir?

MR. GROEDEL: Objection.

You may answer, if you know.

MR. NORCHI: Objection.

MR. WALTERS: Objection.

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

Q. Okay.

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

A. Correct.

Q. Okay.

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

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

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

THE VIDEOGRAPHER: Off the record.

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

CROSS EXAMINATION

BY MR. NORCHI:

Q. It is almost noon, Doctor. Good afternoon. My name is Kevin Norchi, I briefly introduced myself earlier. I represent University Hospitals of Cleveland, and through that, I also represent David Abraham and the

respiratory -- I am sorry -- the radiology therapists. I would like to follow up on some of the responses you gave to questions earlier today.

A. Uh-huh. Yes.

Q. I understand that when you came to University Hospitals of Cleveland, and really started practicing in March of 1998, the radiation oncology department at University Hospitals of Cleveland, albeit generally okay, if I can use that phrase, required some further development by someone of your stature to bring it in line with what was going on in the rest of the medical community in this country, correct?

A. Correct.

Q. And I understand that you implemented a lot of changes to improve the radiation oncology department at University Hospitals?

A. Correct.

Q. If you don't mind, can you outline some of the changes that you implemented in the program from, say, 1998 through the early part of 2001?

A. Well, we talked in terms of developing the system, and that was sort of the challenge that I was given, and the responsibility, as well as developing the integration of radiation oncology with the cancer center, which it hadn't previously been felt to be an integral part, and

which it clearly should have been, and that was the purpose of -- one of the purposes of recruiting me.

From the physician point of view, when I first arrived, there were four physicians, two of which were near retirement. Right now -- and today, we have 13 physicians. So it has increased at least threefold. And the fourteenth will start in July.

The number of patients treated, we were treating between 75 to 90 a day. We are now treating about 300 a day.

We have refurbished a lot of equipment in terms of treatment planning. The decade of the '90s introduced CT scanning in radiation oncology, and this concept of three dimensional conformal irradiation, which wasn't being practiced here, but at that time, by the late '90s, it was more or less the standard of care, and I introduced that system, some of which I helped develop when I was at Wisconsin under a federal grant.

And from the physician, I requested that we specialize in areas of expertise and work with multi-disciplinary cancer teams, and you know, we have accomplished that. So most of the physicians that have joined us since 1998 have one or two tumor sites that they have principal interest in, and interface on a day to day basis with surgeons, medical oncologists,

pathologists, diagnostic radiologists and cancer biologists, for that matter, and basically are responsible for contributing that part to the overall comprehensive cancer center.

When I came, we weren't a comprehensive cancer center. I think I facilitated that award from the National Cancer Institute. And you had to show -- I mean, it was in the so-called pink sheet from the Cancer Center Review, I think in '95, that they were clearly deficient in radiation oncology, and by '98, they made us a comprehensive center, along with other things, but I wasn't principally -- I wasn't solely responsible, but I think I was a major player. So I think that is a case.

Nursing, we have a much better nursing system. I think the nurses are now radiation oncology nurses and are recognized as that, and work with individual team members in terms of specific cancer sites.

So my nurse, Deb Harrp, interfaces with all the gastrointestinal tumor patients with a series of other nurses, as well as physicians. So there is a team approach, and that is how cancer care is delivered today. And that was my challenge.

And the other is to integrate the community sites so that what we do at the UHC and what we do at Southwest General or Mercy in Canton or now Community Health

Partners in Lorain or the Lake University Ireland Cancer Center is, in a sense, the same, the same protocols are available.

We have a system now that we can teleconference so we can have joint rounds, they can participate. All of the multi-disciplinary tumor boards occur in radiation oncology because we had space, but we have become the focus, I guess, of cancer care, as opposed to being an ill used accessory.

Q. Okay.

Who were the four physicians who were in the radiation oncology department when you joined?

A. Dr. Shina, Dr. Novak, Dr. Pham, and Dr. Atunez. And Dr. Atunez was retired shortly after I came.

Q. And where is Dr. Pham, is he still --

A. It is a woman, it is Houng Pham. She is from Viet Nam. She relocated to Seattle. Her husband is a physician, a physical medicine specialist, they got an offer to go to the University of Washington.

Q. And when did she go to Seattle?

A. In January of 2001, I think, or December of 2000.

Q. And is Dr. Novak still affiliated with the Ireland Cancer Center?

A. Yes, yes, he runs the facility at LUICC, at the Lake University Ireland Cancer Center.

Q. And of course, we have heard Dr. Shurin's name, he is still affiliated --
A. No, Shina.
Q. I am sorry, did I say --
A. Shurin is the pediatric --
Q. Medical oncology.
A. Pediatric oncology.
Q. Dr. Shina --
A. Yes.
Q. -- is affiliated still with the program?
A. Right, he is leaving at the end of the month, or early June, I am not sure when his last day is. And he is taking a position in Albuquerque, where he has vacationed the last 20 years. But he has accepted a position there to become chairman of a department at a private hospital there, I think it is called St. Vincent's.
Q. Okay.

What is Dr. Shurin's -- does Dr. Shurin hold a position within the department?

A. No, she is division head of pediatric oncology, so her appointment is in the department of pediatrics.
Q. I misspoke.
A. So that is her only appointment. She is not in the department of radiation oncology at all.
Q. I am sorry, I misspoke. I meant Dr. Shina.

A. Dr. Shina.

Dr. Shina currently is the clinical director, and he was appointed the clinical director when Dr. Michael Samuels left in, I think in -- I think we appointed him in either March or April of 2000.

Q. As part of the changes you have implemented at University Hospitals of Cleveland and the Ireland Cancer Center, did you also implement education strategies, if you will, for the staff? You mentioned the nurses.

A. Right.

Q. Did you implement such --

A. Right, we have had --

Q. -- educational programs for radiation therapists, physicists, dosimetrists?

A. Yes.

Q. Can you tell me what they were and when you did that?

A. Well, one, there is a budget now for travel to meetings that didn't exist. And the physicists, dosimetrists and therapists have their own professional societies, some of which have local meetings, and some of which have national meetings. So that the carrot is to have them present at those meetings, and then obviously then to -- and they are usually sent to a meeting, one meeting a year, just for being on the staff, and if they

are going to present or have some type of committee responsibility in the national organization, then we obviously support that. And the same is obviously true with the physicians.

Q. Okay.

You were asked earlier about the number of pediatric total body irradiations that occurred at University Hospitals of Cleveland since you arrived, and you gave us a number.

A. I am not sure if I gave you that number.

Q. I thought it was 10 to 15.

A. That was 10 to 15 patients --

Q. Oh, that were referred --

A. -- that Susan would refer to me --

Q. I am sorry.

A. -- of pediatric oncology patients in a year, from her practice.

Q. Okay.

If you could, then, I will ask the question, how many total body irradiations on pediatric patients were performed from the time you arrived in March of 1998 to January 26th, 2000?

A. This would be just an estimate, an educated guess, but I would say probably eight a year.

Q. How many under your -- how many of those eight per

year would be under your direction as opposed to Dr. Shina, for example?

A. The majority of them, in the pediatrics. Don did the adults.

Q. Okay.

I was looking at one of the forms that were prepared for the administration of total body irradiation, and it indicates that the -- maybe you can help me, the dose rates --

A. This is A.

Q. I am sorry, under A, Exhibit 13, for example.

A. Okay.

Q. If you look at the top, it says, Dose Rate equals 100 MU, I presume, per minute?

A. Monitor units -- I am sorry, 13?

Q. Yes.

A. Yes, monitor units per minute.

Q. Before January of 2000, had there been a typical practice where the dose rate was higher, for example, around 300, for pediatric total body irradiation?

A. It shouldn't have been, I mean, because the dose rate is -- as we said, is 5 to 10 centiGray a minute. These are just the monitor units based on the calculation that day. We know above that, you get unacceptable acute lung and GI toxicity. And that has been worked out at

St. Jude's in Seattle, going back to the '70s. So I mean, it is --

Q. Is this dose rate, then, of a hundred, what was always given, to your knowledge, for total body irradiation in a pediatric patient?

A. I can't recall. But the dose rate in terms of centiGray per minute should have been -- it can go up to 15, but usually you try to keep it at 5 to 10.

Q. Okay.

You mentioned that there are nurses, individual radiation oncology nurses that would be assigned to a particular attending physician --

A. Correct.

Q. -- is that true?

A. Uh-huh.

Q. And you mentioned Deb Harrp?

A. Correct.

Q. How long had Deb Harrp been working with you?

A. In -- when?

Q. As of January, 2000.

A. She may have started around that time. I would have to look. I know Jill -- what was Jill's last name -- worked from when I started, and then she became the head nurse --

Q. Uh-huh.

A. -- okay? And the head nurse is a supervisory position.

So I interviewed Deb Harrp, and I can't recall exactly when she started. But I think it was sometime late 1999, and Jill was still there as a supervisor for all the nurses. But I have the busiest service, so a supervisor couldn't work for me, just because they are too busy.

Q. With respect to Joshua Valdivieso, what were Deb Harrp's responsibilities in January of 2000?

A. With the pediatric inpatients, there would be very little responsibility.

With an outpatient, principally outpatient radiation oncology nurse, but the vast majority have just had adult oncology experience.

So when the patients come down, there is a pediatric anesthesiology -- anesthesiologist, and usually a nurse anesthetist there. So any dosages, and things like that, are off -- are handled by them.

So our nurses have very little direct supervisory -- supervisory nursing for those particular patients, just because they are so complicated, and they often even will come down with a nurse from the floor.

Q. Okay.

Would you have expected Deb Harrp to see Joshua at

anytime during his admission at University Hospitals from January 20th through the end of the month?

A. Sometimes we would go up on the floor, you know, mostly for a visit. But she would have no direct responsibilities, there is nothing in terms of her nursing care that would need to be extended to the floor.

Q. You would not expect her to report back to you as to whether the total body irradiation had actually gone forward at that time, or where Joshua was in the process of the total body irradiation that you prescribed?

A. Well, I see her every day, we talk, you know. I am not sure what that means. I mean, again, she is not -- that Josh had his second treatment and had his third treatment, we may have said that. But I mean in terms of other things, no, she is not responsible for looking at the dose, for example.

Q. I didn't suggest that she was.

The question was whether or not you would expect her to at least follow the progress of Joshua during the total body irradiation, not to establish that the dose was appropriate or not, just to let you know that the total body irradiation was occurring; is that something you would expect her to do or not?

A. Correct. But as I mentioned before, with the long hours, the nursing oftentimes -- I principally see

patients all day Monday, Tuesday and Wednesday, oftentimes from 8:30 until 6:30 or 7:00. So Deb works those three long days, and then sometimes she would work shorter days or not work a Thursday or Friday, because the hospital says work 40 hours and they can't pay -- no, I mean, that is how we set it up, so, you know, she -- she has agreed to that, which is --

Q. Okay.

So the hours that she works conform with what your schedule requires?

A. Right.

Q. And you essentially tell her what her hours will be?

A. No, no. She has a nurse supervisor. But it is fairly predictable from week to week, of when I see -- my on treatment patients are typically on Mondays, and I see follow-ups on Tuesdays, and Wednesdays I see follow-ups and do patients, on Thursdays and Fridays I will see some new patients.

But you know, there is less direct clinical activity on Thursdays and Fridays, so oftentimes she may work for someone else during those times, or may take her comp time.

Q. Specifically with respect to Joshua, do you know whether you or Deb, separately or together, visited

Joshua in the hospital?
A. I can't recall.
Q. And of course, you know David Abraham, correct?
A. Yes.
Q. And he no longer works at the hospital?
A. Right.
Q. Do you recall him to be a competent dosimetrist?
A. Yes.
Q. And you had worked with him for at least a couple of years; is that true?
A. I am not sure if he was there that long. I would have to look at his record. I think he probably -- at least a year, it may have been longer.
Q. Okay.
Well, during the year that you recall him working at UH, he had prepared or calculated doses for patients, some of your patients for whom you had given prescriptions, correct?
A. Absolutely.
Q. Okay.
Have there ever been any occasions where he felt that the dose was unusual and bring that to your attention?
A. Possibly. I can't recall a specific, but possible.
Q. Okay.

Well, let's not make it specific with David Abraham. Have there ever been any times when a dosimetrist would bring to your attention what they thought to be an unusual dose or an unusual prescription that was written by you?

A. Yes.

Q. That is not an unusual occurrence, is it?

A. No, no.

Q. Because of your busy schedule, as you have just described for us --

A. I would call it uncommon.

Q. You would call it uncommon?

A. Yes. Usually my technique is to write and dictate very detailed notes, and often the comment from the dosimetrist and the therapist is they know a lot about the patient by the time they end the note. And so I try to get it right the first time in so many words. So you know, usually there is not a discrepancy.

And I tend to see more complicated patients, and some unusual patients that previously hadn't been treated in the department because of -- they would be referred elsewhere.

Q. Right.

Well, and because of the unusual patients you might see, you would also have atypical treatment plans,

correct?
A. More complicated. Maybe not atypical.
Q. Well, more complicated in that the dosimetrists may not have seen that particular type of prescription or treatment plan in the past, fair?
A. Correct, correct.
Q. Let's go back to those situations that, I mean, you described as uncommon, but where a dosimetrist would have a question about the dose or the prescription. Would the communication with you, between you and the dosimetrist, be by a Post-It note or some note stuck to the chart and then the chart would be put in your mailbox?
A. Possibly.
Q. Okay.
A. Not my mailbox. My office, everything occurs in the clinic.
Q. Okay.
A. I am there throughout the work day, four of the five days. So, you know, I am in there, so oftentimes they just communicate it by orally.
Q. But you have been in situations where there would be --
A. Yes.
Q. -- a communication with a Post-It note, or some other note stuck to the chart, correct?

A. Correct.
Q. And then you would respond and write on the note and return it back to the dosimetrist?
A. Possibly, or walk it back.
Q. But that is one method -- that is one manner of communication that would occur between you and a dosimetrist, for example?
A. Yes.
Q. Is that the same -- well, would you also communicate in that same way with a physicist who had questions?
A. Possibly, but more directly by mouth.
Q. More typically by oral communication?
A. Oral communication, yes.
Q. Okay.
Have you spoken to Deb Harrp about this lawsuit at all, the litigation?
A. No, I have not.
Q. And has she spoken to you about it?
A. No, she has not.
Q. You are affiliated with a practice group, it is University Radiology --
A. Radiation Medicine Associates.
Q. Is that a corporation?
A. Yes, it was one of the -- becoming a chair here in

1998, you set up a corporation. It was pretty strange, but anyway -- I had never done anything like that. But subsequently, there is sort of a boiler plate, they are all the same. But at that time, they weren't.

So I was responsible for it, and I actually used a lawyer that had set up a practice plan before, and we just sort of did it. But it was approved by the hospital and the medical school.

Q. Sure.

Is it that practice plan through which you bill patients?

A. Correct.

Q. Okay.

Are you an officer or shareholder in that?

A. The president.

Q. The president, okay.

Are there any other employees of the group, that you are aware of?

A. Since we have gone into the UFPA, I think they have called it now, the University Faculty Practice Associates, and we have had to pick up employees, so I am not sure how many there are.

Q. Okay.

A. It is a bone of contention, because we are paying for things that seemingly we are --

Q. You don't want to have to pay for.

MR. GROEDEL: Doctor, just answer the question, okay?

A. Okay, sorry.

Q. What is your affiliation with UFPA, University Family Practice Associates?

A. No, no, it is University Physicians Faculty Association.

Q. Okay.

A. So the family practice would be part of it, and we would be part of it. So all the practice plans.

Q. Okay.

Do you, through your practice plan, provide any benefits to any of the nurses?

A. No.

Q. Okay.

The dosimetrists?

A. No.

Q. How about the physicists?

A. No.

Q. Mr. Margolis asked you a couple of questions about -- well, it is Exhibit A-1, the prescription note. Let me just follow up with a couple others.

A. Okay.

Q. I apologize if they are repetitive.

Actually, Exhibit A-2, Bates stamp Number 2 on it, this is a prescription or a therapy prescription, and this was filled out primarily by you, correct?

A. Correct.

Q. Okay.

I see your signature on the upper -- the M.D. signature on the 1-17-2000 box.

A. Uh-huh.

Q. Is that written over at all --

A. No.

Q. -- on your copy?

A. No. It looks like the T and the K are superimposed.

Q. Okay.

Which is a little dissimilar from the one below it, correct?

A. Right, which is dissimilar from the one below that, unfortunately.

Q. And then I saw another signature that you make, it looks like a squiggly line, it looks almost like a W; do you recall that? That was from the May therapy.

A. Yes, I think you can look throughout, my strength is not in Palmer.

Q. Okay.

One of the things that I am interested in is, when you did look at this on May 10th to write a new

prescription --
A. Correct.
Q. -- what records and documents did you have available for you when you wrote the therapy prescription note here?
A. I would have that chart (indicating).
Q. Okay.
A. That would be it. I would have -- since Joshua is an inpatient at that point, I would have his inpatient records, or actually just his chart from that admission from Rainbow Babies.
Q. From May?
A. From, yes, the May 10th. I assume he came in that day.
Q. You wouldn't have the January admission?
A. No.
Q. Okay.
A. No.

MR. MARGOLIS: Excuse me, just so that the record is clear, the witness motioned to that chart, and I think he meant Exhibit 101.

THE WITNESS: 101, I am sorry. Thank you.

BY MR. NORCHI:
Q. Contained in -- would you have reviewed Exhibit 101 to look at the prior total body irradiation

treatments that were given?
A. Well, I may have. But --
Q. Is it your usual custom and practice, when a patient comes in with a recurrence, to look to see what prior treatment he has received?
A. Yes.
Q. Okay.
And the prior treatment would be reflected in your chart, the Exhibit 101 that you have in front of you?
A. Correct, correct.
Q. And again looking at Exhibit 101, you would have seen the calculation done by the dosimetrist and checked by the physicist?
A. I would not have looked at that.
Q. Okay.
Do you ever look at those forms?
A. Yes, I -- yes.
Q. Under what circumstances would you look at those forms?
A. Since I don't sign them, I have probably glanced at them. I don't -- I mean, they are important documents, but again, I certainly will sign off on those types of things in the future, but I don't think I did that day.
Q. Okay, I understand.

I am just wondering, what stage in the process --
A. Right.
Q. -- would you look at --
A. When I am writing a note --
Q. -- the calculation sheets?
A. Rarely.
Of an old calculation sheet?
Q. Yes. Well, in a case such as this, Joshua --
A. I wasn't aware, I mean, I just assumed, because I am writing the note here, okay (indicating)?
Q. On January 17th.
A. Right, I am looking above -- I am writing the note on 5-10, it says, see consult note, I am seeing that. If you look in the front of the chart, on the face sheet, you can see 10 Gray. So I mean -- and obviously in the hospital record, on January 26th, I wrote the right thing, I mean, it was a -- you know, an error, it was a mental mistake.
Q. I understand.
A. And I carried -- unfortunately, I carried it through.
Q. And I think you did answer this, but on 5-10 and 5-18, looking at Exhibit 2 on the therapy -- which is the therapy prescription note, if you would have looked at the top line, you would have seen that only 1 Gray --

A. Right.
Q. -- was provided, correct?
A. Right.
Technically, I should have started prescription Number 2 on 5-10, a separate sheet. So I mean, this -- then this would have been folded back.
Q. Is there any reason why you didn't do that, that you can think of?
A. It was an emergency, the child was there, probably the people hadn't put the right form in. Usually one of my -- the clerical people would have put a new prescription in. So I open the chart, and I would see a new prescription -- a whole new face sheet. And it wasn't there. So it is either take down the chart and ask them. The patient was under anesthesia, so I took the path of least resistance.
Q. Was it your custom and practice to try and write a note in your chart every time the patient had treatment, or was it just to write a note at the beginning, and then an ending note?
A. In patients getting weeks of treatment, we write a note once a week. If there is a change or a resimulation, that requires an additional note. But a typical, every five fractions you write an update note.
Q. Okay.

And so the process you would have used in this is, as you mentioned, you would write the January 17th note that would identify the prescription, you would fill out the prescription sheet --

A. Right.

Q. -- that would get passed on to the dosimetrist to prepare --

A. Correct.

Q. -- the calculation?

A. Correct.

Q. And then that would be checked by the physicist?

A. Correct.

Q. And if either of them had problems or issues with the dose, they would come to see you?

A. Correct.

Q. Okay.

And of course, you have testified you don't recall any discussions with either?

A. Right.

Q. And then the physicist would then check that.

Who would be present at the time of the total body irradiation, other than the respiratory -- I am sorry -- the radiation therapist?

A. Sometimes the physicist would be there. I mean, it is ongoing, so they would be there to check the setup

and things.

Q. And what do you mean by setup?

A. Well, the patient is placed at three meters from the radiation beam, the linear accelerators, and it is actually marked out, and there is a special shield that is placed in the -- between the patient and the machine, plus these things called diodes, which record the radiation dose, are placed on the patient at certain locations. And either a dosimetrist or a physicist does that, or both.

Q. Okay.

Can you tell from the record who did that in this case?

A. Let me see.

On the 26th, it looks like the physicist was Sam Beddar, there is no dosimetrist, and it looks like the same on the -- I am not sure who was on the 28th -- or the 29th -- I am sorry, on the 28th.

I can't tell you that, those days, specific days, besides it looks like it is Sam Beddar the first day.

Q. I didn't have a copy of your CV, so I apologize, I will have to ask this question blind, without reviewing it.

Have you ever written any articles or made any presentations regarding treatment of children through

total body irradiation with 1 Gray or smaller doses?
A. Yes.
Q. And when? Do you want this (indicating)?
A. In 1983, there is an article in --
MR. GROEDEL: He just asked you when.
A. (Continuing) Oh, 1983, sorry.
MR. GROEDEL: There you go.
Q. I am going to follow up.
A. It has got low-dose TBI in the title, it is in Ewing's sarcoma, '83 or '84.
Q. Can you tell me which one it is, then?
A. I think I am the first author. It has got low-dose -- Number 18.
Q. And it is an article in which you are the first author, and it says, Intensive combined modality therapy including low-dose TBI in high-risk Ewing's sarcoma patients, correct?
A. Correct.
Q. Is there any -- well, is that article at all relevant to any of the issues in this case?
A. Well, the doses, it was 15 centiGray twice a week for five weeks at a total dose of 150 centiGray. It was an experimental study carried out at the National Cancer Institute of an approach using total body irradiation.
Q. I see from your notes of 5-11, patient notes -- it

is Page 4 of Exhibit A.

A. 5-11.

Q. Yes, see it?

A. I see a note from Deb Harrp.

Q. Okay, that is Deb Harrp's note?

A. Right. Patient, mom and dad came down to radiation oncology, given teaching information, signed consent and schedule of treatments. Patient will be outpatient starting tomorrow. Deb Harrp, R.N.

Q. Okay.

Was the brain therapy that Joshua received outpatient therapy?

A. It started as an inpatient, because they are saying -- Deb's note says he is being discharged.

Q. Right.

A. So his first two treatments on 5-10 and 5-11 must have been as an inpatient and subsequently as an outpatient.

MR. NORCHI: Thank you, Doctor. I don't have any further questions.

CROSS EXAMINATION

BY MR. WALTERS:

Q. For the record, I am Steve Walters, I represent Case Western Reserve University and the two physicists, Dr. Barry Wessels and Dr. Sam Beddar.

Doctor, I have very few questions at this point, because most of them have been asked.

A. Okay.

Q. Which is good news for everyone.

If I understand, Dr. Kinsella, you do design protocols for radiation therapy that are experimental on occasion?

A. In the past, when I worked at the National Cancer Institute, all of the treatment we gave was experimental by design. Only patients could be treated on experimental protocols at the National Cancer Institute.

Q. With regard to radiation therapy which you have caused to be performed at University Hospitals, as a comprehensive cancer center as designated by the National Cancer Institute, are you on what I will, for want of a better term, use, cutting edge of radiation oncology?

A. Yes, I would consider it today.

Q. And I understand that that has been through a great deal of effort since you have arrived there some four years ago --

A. Right.

Q. -- four and a half years ago.

There are protocols in which children, pediatric patients, are given total irradiation of 1 Gray?

A. Total body irradiation of 1 Gray? No, not today.

Q. Not today.

With regard to the involvement of the dosimetrist and the physicist, I want to clarify some questions that were already asked, I think by Mr. Margolis, but I will try not to be repetitive.

Am I correct that neither a -- that a physicist is not permitted to write a prescription for dosage?

A. Correct.

Q. The physicists do not determine what the dosage should be, that is something that is exclusively the province of the radiation oncologist?

A. Correct.

Q. And in the case of Joshua Valdivieso, that was -- there was no difference in that arrangement?

A. Oh, correct.

Q. In fact, by law, as you understand it, physicists are not permitted to make that determination?

A. Correct.

Q. You may not be familiar with the training of physicists, but am I correct that they are not trained, as you are trained, in determining what constitutes a therapeutic dose for various cancers?

A. Correct.

Q. And if a physicist were to question your judgment on what is therapeutic or subtherapeutic or, moving to

the other direction, toxic, that is not an appropriate thing for a physicist to do, is it?

A. They could question it.

Q. How would you receive them questioning your judgment about what is appropriate dosage?

A. I would explain the reason why I prescribed that dose.

Q. Has that happened since you have been at University Hospitals, where either a physicist or a dosimetrist have questioned your dosage, and you have explained to them why that was the correct dosage?

A. Yes.

Q. Obviously you don't have the time to do that on every case?

A. Oh, correct.

Q. It wasn't clear to me, but if I am correct, Joshua was scheduled to receive his total body irradiation in three fractions?

A. Correct.

Q. And they were scheduled to be done on January 26th, 27 and 28?

A. Correct.

Q. Would you have seen Joshua on each occasion when he was there to receive a fraction?

A. I am not required to see him. I usually would see

him.

Q. In this specific case, do you recall whether or not you did?

A. I saw him on the 26th and wrote a note for sure.

Q. Okay.

And that is the note you referred to before that is in apparently the University Hospitals chart?

A. Right.

Q. And you may have answered this, bear with me. That was put in the University Hospitals chart rather than in your departmental chart, Exhibit 101, for what reason?

A. Joshua was an inpatient, and I am communicating to the inpatient team what we are doing in the radiation oncology clinic, which, as you know, is a long way from -- and the expectation, so that they know they are scheduling his bone marrow transplant three days from now.

Q. And typically is that the way it works, when a patient is being seen or treated in your department as an outpatient, the record keeping is done in your departmental record, such as Exhibit 101?

A. Correct.

Q. And when they are an inpatient, the records -- record keeping or notations are made in the hospital

chart?

A. Sometimes both places. We are communicating to different groups. If I am communicating the schedule that is important for the floor and physicians on the floor to know, I would give that information. If there was another bit of information, say, scheduling a second simulation, that the floor would not know what those words meant, I would simply put it in our chart.

Q. Now, I noticed in the case of Joshua, you dictated a lengthy note that was then typed up for your encounter of January 6th, 2000, and I think you were asked questions about it, correct?

A. Correct.

Q. And then I noted also that you dictated a note, not quite as lengthy, but still a fairly lengthy note on May 10th?

A. Correct.

Q. What is the criteria by which you decide when to dictate a note as opposed to just write a note out?

A. Well, a consult note is often long, and I haven't got the time to write it. So usually I will write -- sometimes I will write a brief note, but say, full note dictated. I will then give it to my secretary, and usually we put it in the chart that day. So they actually have that, and it is appreciated, because it is

much more detail, and it can be read, it is legible.
Q. In, I guess Plaintiff's Exhibit A that we have been making reference to periodically in this deposition, on Page 4, there is your handwritten note of January 17th?
A. Correct.
Q. Am I correct that the treatment plan as of January 17th was different than the treatment plan contemplated when you dictated your January 6th note?
A. Correct.
Q. And I think you explained that, there had been some additional staging, and to put it in layman's terms, this was a worse situation than you had anticipated?
A. Correct.
Q. There are no other notes until there is one beginning 5-10?
A. Right, correct.
Q. Am I correct that when that says 5-10-99, that is a mistake, of course?
A. That is correct.
Q. It is 5-10-2000?
A. 2000, yes.
Q. By 5-11, that -- somebody -- well, I guess you, pick up the mistake and begin using the proper year?
A. That is Deb Harrp's note, but that is the correct

year, yes.
Q. Okay, all right.
A. By 5-16, I picked it up.
Q. All right.
Which is on Page 5 of Exhibit A?
A. On Page 4, 5-16 note.
Q. It is 4, okay.
Dr. Kinsella, turning to Page 1 of Exhibit A --
A. Yes.
Q. -- this is the prescription, there has been talk about prescription. This is the prescription, correct?
A. Yes.
Q. And only a physician can write that?
A. Correct.
Q. And it is the prescription that then triggers the calculations that the various people go through as far as setting up the machine, calculating how to deliver the radiation?
A. Right, correct.
Q. We talked a lot about the line for January 17th on Exhibit 1, which you have indicated contains a total dose of 1 Gray, and should have been 10 Gray, correct?
A. Correct.
Q. Down below that is -- the very next prescription you wrote was on May 10th?

A. Correct.
Q. And on Exhibit 1, that says 35 Gray?
A. Correct.
Q. So -- and that is your signature or initials to the right, correct?
A. Yes, it is.
Q. So when you wrote that, you would have seen your earlier prescription, correct?
A. Should have. I mean, it was there.
Q. Understand. Yes, I am not quibbling with words.
Would that have been the first time you would have had the occasion to see that 1 Gray prescription of January 17th?
A. Well, I saw that I wrote a note on the 26th in the hospital chart, so this chart would have been available during the treatment. But after the total body irradiation was given, I did not see Joshua in follow-up at any time, so this would have been the next time I would have seen this.
(Thereupon, Mr. Margolis left the room.)
Q. Let me ask you this:
Would there have been any -- have been any reason for you to make reference to the therapy prescription sheet between January 17th and May 10th?
A. During the treatment itself, the TBI, I certainly

could have seen it and should have seen it. So while he was getting treatment, and while I wrote the note in the chart, the hospital chart, the patient and the radiation oncology record are usually there in the outpatient clinic.

Q. Now --

A. I can't recall whether I specifically had this chart in front of me when I wrote that note in the hospital chart.

Q. But when you wrote the May 10th prescription, obviously since it is only two lines below, or an inch away, you did have it front of you?

A. Yes.

Q. Sure.

Exhibit A-2, which is the next page --

A. Yes.

Q. -- there is -- and I think you have explained this -- the 35 Gray for the May 10th prescription is crossed out and there are some other numbers put in and circled. That is your writing, correct?

A. Yes.

(Thereupon, Mr. Margolis reentered the room.)

Q. And the total number of fractions are changed from 14 to 7?

A. Correct.
Q. And that is your changes?
A. Yes.
Q. Those changes were made at the time -- and I am drawing the distinction between that and the situation you described earlier in response to Mr. Margolis' questions about something done after the lawsuit.
That was done -- the changes for May 10th were done intentionally and at the time Joshua was under treatment?
A. They were done on 5-18.
Q. Okay.
In doing that, you would have again had the opportunity to see the 1 Gray prescription that you had written back on January 17th?
A. Correct.
Q. If you compare Exhibit A-2 with Exhibit A-3 --
A. Yes.
Q. -- is there any change to the prescription sheet between those two, other than what you have already testified to, and that is the change that was made after the suit was filed on the January 17th prescription?
A. Not that I can see.
Q. I haven't seen any, either, but I thought maybe you might pick it up if I have missed it.

A. (Witness shakes head).
Q. Would you agree that a radiation oncologist is more apt to recognize the inappropriateness of a radiation dose than would be a nonphysician?
A. Oh, absolutely.
Q. Now, you gave testimony in response to questions by Mr. Margolis with regard to the prognosis for this young man.
A. Yes.
Q. Am I correct in my understanding of your testimony that at least as of the time that Joshua was restaged in early January of 2000, his prognosis was rather dismal?
A. Correct.
Q. And I think you already quoted some statistics with regard to that.
A. I gave an estimate --
Q. Yes.
A. -- my estimate.
Q. Am I correct that in your practice as a radiation oncology -- oncologist, the fact that a given patient's chances of survival, even with cutting edge therapy, the most appropriate therapy available, is poor, you will not, on that basis alone, deny them the at least possible benefit of receiving the therapy?
A. Correct.

Q. And in the case of Joshua Valdivieso, it was that view of giving him whatever chance, albeit small that he had, that you agreed to provide him with total body irradiation?

A. Correct.

Q. Is there some rule of thumb as to the duration of time, or the period of time over which fractions must be given if they are to have any salutary effect on a patient?

A. Well, typically radiation is given once a day, in some settings, it is given twice a day. And we think the delays in radiation -- and there is information to suggest that, that intentional breaks can have an adverse outcome. So prolonging a course of treatment for various reasons, this is principally in adult cancers, cervix cancer and lung cancer.

Q. Am I correct that as you look at the case of Joshua Valdivieso, at least from the standpoint of radiation oncology, the dosage given, the time given, the fractions given, in all probability made no difference in terms of his ultimate outcome, which was to succumb to his cancer?

A. That is what I believe.

Q. Dr. Kinsella, both before Joshua Valdivieso and after Joshua Valdivieso, have you had occasions to work

on cases in which either Dr. Barry Wessels or Dr. Sam Beddar have been involved?

A. Yes.

Q. Have you found them to be competent and conscientious physicists?

A. Yes.

Q. Were your responses to any of the questions by Mr. Margolis intended to indicate that you believe that in the case of Joshua Valdivieso, either Dr. Wessels or Dr. Beddar fell below the standard for physicists?

A. Absolutely not.

MR. WALTERS: That is all I have.

MR. MORIARTY: Do you have more than five minutes?

MR. SWEENEY: No, probably not, actually.

MR. MORIARTY: Do you have more than five minutes?

MR. MARGOLIS: Yes.

MR. MORIARTY: Then I need five minutes.

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

(Short recess had.)

MR. MARGOLIS: Doctor, did you indicate --

MR. GROEDEL: Wait, Tim had questions.

MR. MARGOLIS: What?

MR. WALTERS: Wait your turn.

DR. WIERSMA: Wait your turn.

MR. MARGOLIS: Oh, I am sorry, Tim, I apologize.

MR. SWEENEY: That is okay, as it is going to turn out, you might as well go ahead. After looking at my notes, I am going to pass.

Thanks, Doctor.

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

RECROSS EXAMINATION

BY MR. MARGOLIS:

Q. Doctor, is it Dr. Shina who you said is leaving to go to Mexico?

A. Correct. New Mexico.

MR. MORIARTY: New Mexico.

A. (Continuing) New Mexico, Santa Fe.

Q. All right.

Going back to this meeting where you may or may not have altered the record and Dr. Wiersma was present, you were aware certainly prior to today that one of the allegations in this lawsuit involved an alteration of records?

A. Uh-huh, right.

Q. And Dr. Wiersma purportedly would have been a

witness as to whether or not you would have altered the record at this meeting after the lawsuit was filed.

You are testifying today that you have never discussed with Dr. Wiersma what her recollection is of whether or not you altered the records at this meeting after the lawsuit was filed?

MR. GROEDEL: Objection.

First of all, any conversations that Dr. Kinsella had with Dr. Wiersma would be protected by spousal privilege. So I am going to instruct him not to answer the question just based on that basis alone.

MR. MARGOLIS: Except if she is going to testify as to what she saw, then that portion of the privilege is going to be abrogated by her, and I can certainly ask him what his understanding is of her knowledge.

Q. (Continuing) Let me phrase the question this way:

Because you and Dr. Wiersma are married, there is a legal privilege that applies. We will argue it in front of the judge, and the judge will make a determination.

For the purposes of my questioning today, do you have knowledge as to whether or not Dr. Wiersma recalls you altering the record, which is record 102, at this meeting that occurred after the lawsuit was filed?

MR. GROEDEL: Objection.

You may answer, if you know.

A. I am not sure if she was there at that time.

Q. Okay, all right.

You have been involved in pediatric oncology and radiation oncology for how many years?

A. Since 1980, when I went to the National Cancer Institute.

Q. Have you ever known children to beat the odds, that there are successes or miracles that medically you just say, no chance, not going to happen?

MR. GROEDEL: Objection.

You may answer.

MR. WALTERS: Objection.

MR. NORCHI: Objection.

A. Not really. I mean, unfortunately, they often are predicted by -- by the disease status. So we know pretty well what will happen.

Q. One hundred percent of the time?

MR. GROEDEL: Objection.

You may answer.

MR. WALTERS: Same objection.

MR. NORCHI: Objection.

A. We are pretty sure most of the time.

Q. That isn't what I asked, though.

Have there ever been children who you believe, based upon your skill, education, knowledge and experience, that they are not going to survive secondary to their disease beyond a certain time period, and lo and behold, they surprise everybody and they do?

MR. GROEDEL: Objection to the vagueness of the question --

MR. WALTERS: Objection.

MR. GROEDEL: -- but you may answer.

MR. NORCHI: Objection.

A. Theoretically.

Have they lived longer than I might have guessed? Yes. Have they been cured? Probably not, unfortunately.

Q. Now, if a patient, a child, has an extremely poor prognosis, and you don't really anticipate that the medical treatment that you are providing is going to have any meaningful impact upon the patient's prognosis either for cure or survival, is that something that you are duty bound to inform the parents of so they can make an informed choice of treatment?

A. In that setting, those -- as you have phrased the question, I would say yes.

Q. All right.

And your testimony is that after you saw Joshua and you had this detailed note of January 6th, that you

saw him again on January 17th where, based upon his medical condition and modifications, that there was a change from your perspective what would be most appropriate treatment, and it would be TBI, correct?

A. Correct.

Q. And your only January 17th note is what is on Page 4 of Exhibit A, correct?

A. Correct.

Q. At any point do you document that you informed Joshua's parents that you really didn't think that this treatment was going to have a snowball's chance in hell in benefiting this child?

MR. GROEDEL: Objection.

You may answer.

Q. (Continuing) Is that documented anywhere in your January 17th note? Look at the note.

A. No.

Q. As a matter of fact, on January 20th -- if you want to go to Dr. Wiersma, and look at Page 4.

MR. WALTERS: We don't have this.

MR. MORIARTY: What is the exhibit number?

MR. MARGOLIS: 4.

MR. GROEDEL: Is this going to be marked as an exhibit? This is something we haven't seen.

MR. MARGOLIS: Right, I am going to give --

I will mark it as an exhibit. Let me do this --

MR. MORIARTY: I am just saying, the other ones had a letter, A, page something --

MR. MARGOLIS: Right.

MR. MORIARTY: -- B, page something. What is this one?

MR. MARGOLIS: This does not have a letter, because there is only one folder that is delineated Dr. Wiersma.

MR. MORIARTY: Okay.

MR. MARGOLIS: It is marked Exhibits 1 through 32.

Q. (Continuing) So I am handing you the Dr. Wiersma folder, and asking you to refer to Page 4.

A. Yes.

Q. And at that point, was it not represented as following to the parents: "It is hoped that this procedure will benefit my child. There is no guarantee that my child will experience a continued remission. It is hoped that the radiation and high-dose chemotherapy will kill tumor cells. It is hoped that the combined treatments will increase my child's chance to remain well. It is hoped that the treatment will decrease the risk that the tumor will return or relapse." And then that is signed by the child's parents on January 20th of 2000?

A. Yes.
Q. All right.
So with everything that all the doctors knew that were taking care of Joshua in January of 2000, you never said to the parents, I think that this TBI is hopeless, or we don't have any hope whatsoever that this will benefit your child; it was represented that this could have a potential benefit to this child, wasn't it?
A. Yes.
Q. And if you would have thought in January of 2000 that TBI had absolutely no chance of benefiting this child, it would have been medically unethical for you to administer that treatment?
A. I didn't say that.
Q. I didn't ask you what you said. I asked you to answer what I asked.
Would you read the question back.
A. Yes, please.
(Record read.)
A. (Continuing) Yes, correct.
Q. And you would agree with me that it would have been unethical for any other health care professional to have recommended the treatment under these circumstances if the consensus of opinion was there was no chance that

this was going to help this child?
A. Yes.
Q. Has your status at University Hospital been changed at all relative to the filing of this lawsuit, have you been put on probation?
A. No.
Q. Are you aware as to whether or not there is any impending investigation surrounding your potential summary suspension based upon the facts of this lawsuit and deposition?
MR. GROEDEL: Objection.
A. No, I do not.
Q. There was a physicist who you testified had left, or a dosimetrist, I believe, Mr. Abrams [sic]?
A. Yes.
Q. Where did he go?
A. I think he is at Akron City Hospital now.
Q. Have there been instances in the course of your practice where you have told patients' parents, I just simply will not do any more treatment on this child because it doesn't have any -- it is not medically warranted --
A. Yes.
Q. -- if there is no chance of benefit?
A. Yes.

Q. And that is something that you believe, as a physician, you have the obligation to do if the situation merits it?

A. Yes.

Q. The last question I have, if you look at -- or line of questioning. If you look at 10- I think it is -2, which is the prescription sheet --

A. Yes.

Q. Is it 102, sir?

A. Let me see.

MR. GROEDEL: Yes.

A. (Continuing) Yes.

Q. I thought you said earlier that normally every time a prescription is written, that it is written on a separate piece of paper, that it is not done sequentially; is that accurate? Was that your testimony?

A. When I came, we would do -- when I started at UH in 1998, we would do it on the same, and then some patients would carry over. It got to be very sloppy and hard to follow.

So a policy was made that if a patient comes back for a retreatment or a second treatment, then the clerical staff, and things like that, should reorganize the chart with a new prescription sheet, and then this would go behind that.

Q. All right.

And when did that change in policy take place?

A. I am not sure whether it was before or after this time.

Q. All right.

A. But in today -- today, there would have been a fresh sheet here that I would have then put, whole brain, it would have been Number 2, and the stage would have changed, it would be X, it would be relapse, so some things would have changed.

Q. You indicated in answer to Mr. Norchi's questions that in May, when you did additional prescriptions for radiation, that you would have reviewed the child's chart inclusive of the January treatment that he had received, correct?

A. I may have.

Q. Well, what would be your standard operating procedure under these circumstances? You have a child with a remission, the child has --

A. Right.

Q. -- been previously treated with radiation. Wouldn't you want to look at what the prior radiation treatment was before you determined what treatment you were going to recommend now?

A. Yes, yes.

Q. All right.
A. And -- but my -- it was 10 Gray, and it was here (indicating), and it is on that note. So that is -- I mean, that is how I saw it. I mean, it was a mental lapse.
Q. I understand that.
A. And --
Q. And it is your testimony today under oath that had anybody brought to your attention that Joshua Valdivieso did not receive 10 Gray of radiation during his TBI on January 26th, 27th and 28th, if anybody would have brought that to your attention, you would have advised the parents of the fact and evaluated whether or not a change in his medical treatment would have been warranted?
A. Right.
Q. And the first time that you knew that this child received 1 Gray was after the lawsuit in this case was filed?
A. Correct.

MR. MARGOLIS: Thank you.

MR. NORCHI: I have just one follow-up question.

MR. MORIARTY: No.

MR. NORCHI: Please? One subject.

RECROSS 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.

MR. GROEDEL: Oh, I am sorry, Steve.

MR. WALTERS: Well, I have none.

MR. GROEDEL: Oh, you have none. I am sorry.

MR. MORIARTY: He will read and sign.

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(DEPOSITION CONCLUDED)

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Timothy J. Kinsella, M.D.

CERTIFICATE

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

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named TIMOTHY J. KINSELLA, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 6th day of May, 2002.

Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.
My commission expires November 5, 2003.