IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

GLORIA MASLANKA, Individually and as Parent and Natural Guardian of Shane Maslanka,

Plaintiff,

versus

METROHEALTH MEDICAL CENTER,

Defendant.

CASE NO. CV-05-552424

JUDGE McDONNELL

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Deposition of **JOSEPH SCIARROTTA, M.D.**, a Witness herein, called by the Plaintiff for Cross-Examination pursuant to the Ohio Rules of Civil Procedure, taken before the undersigned, Christine Leisure, a Notary Public in and for the State of Ohio, at MetroHealth Medical Center, 2500 MetroHealth Drive, Legal Department, Cleveland, Ohio, on Wednesday, January 11, 2006, at 10:15 a.m.

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APPEARANCES:

On Behalf of the Plaintiff:

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I N D E X

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WHEREUPON,

JOSEPH SCIARROTTA, M.D.,

after being first duly sworn, as hereinafter certified, testified as follows:

CROSS-EXAMINATION

BY MR. KULWICKI:

Q. Doctor, if you would kindly state your full name and spell your last name.

A. Joseph Sciarrotta, S-c-i-a-r-r-o-t-t-a.

Q. And, Doctor, we're here in a case of Maslanka versus MetroHealth Medical Center. It's my one and only opportunity to take your deposition and find out what you recall about your involvement in the care of Gloria Maslanka. I'm going to ask you a series of questions and we'll get a chance to look at your notes in the record and ask you about those as well.

During the course of the deposition please tell me if you need to take a break for any reason. I think it might take as long as two hours. I'm hoping it won't, but it may take that long. So just tell us --

A. At my age I may need a couple of body breaks.

Q. We will certainly accommodate that.

A. Thank you.

Q. Likewise, as you're doing, speak up, speak verbally in answer to my questions rather than an uh-huh or an uh-uh or a nod of the head, because our court reporter can't take those down.

A. Right.

Q. And we'll remind you if you forget so don't worry about that.

A. Thank you.

Q. And, finally, if I ask you a question that you don't understand or you can't hear, tell me that and I'll restate it so that you understand me. I don't want to try to trick you. I want to just make sure you and I are communicating fairly here. Okay?

A. Okay.

Q. Why don't I start by asking you if you're currently employed by MetroHealth?

A. No, I'm not.

Q. Are you retired?

A. I'm retired.

Q. Tell me when you retired.

A. I retired in June of 2003.

Q. Tell me how long you had been employed by MetroHealth from June of 2003 going back in time.

A. I started in November of 1991.

Q. Are you currently involved in any medical practice or professional activities?

A. No.

Q. Before joining MetroHealth in 1991 where did you work at?

A. I retired from my private practice in 1988, I was a medical director for Park Davis for almost two years, and then I worked one year as a staff physician at one of the local hospitals as on-call physician, and then I started here in '91.

Q. The care that you provided to Gloria Maslanka took place in July of 2001, so I'm going to ask you some questions about that time frame. Were you board certified in obstetrics at the time?

A. Yes.

Q. And were you board certified in any other specialty at that time?

A. No.

Q. Tell me -- I know that at least from my review of the records you saw her at the McCafferty Clinic at least once. Is that the one and only time that you saw this particular lady?

MR. MALONE: With respect to this pregnancy? He may again have been involved in priors.

MR. KULWICKI: Fair enough.

A. With this pregnancy, as far as I know, yes.
Q. And have you had the opportunity to review your notes from that particular visit?
A. I have gone over them with him.
Q. Good. Thank you. Let me ask you a little more about your background and then we'll look at those notes. Have you had your deposition taken before? And that's what we're doing right here where there's a court reporter taking down your testimony.
A. For this?
Q. No, in any other case.
A. Not related to obstetrics.
Q. All right. Fair enough. Have you ever acted as an expert witness in a medical malpractice case?
A. No. Excuse me. I do take it back. I'm sorry.
Q. Okay.
A. It was a case in my practice, there was a serious auto accident and we had to go ahead and do emergency surgery on the patient. She had fractures and all kinds of things. I was asked to testify in that as her attending physician. I'm sorry, I forgot that.
Q. Thank you. Although you're not active, do you have a Curriculum Vitae or would you have one on

disc that you could print up?

A. I have one but not on me.

Q. If I ask Mr. Malone could you get that for me at some point in time?

A. I'll send it to him.

Q. That would save us some time. Now, I had the pleasure of deposing Dr. Ashmead yesterday, I think it was, and he was telling me a little bit about subspecialties within the area of OB and he used the term a "generalist". Hopefully I'm using those terms correctly. But would you consider yourself a generalist in the field of obstetrics?

A. In this organization, yes, because we have so many subspecialties.

Q. All right. Did you have any particular area of interest in obstetrics?

A. No, just general obstetrics.

Q. And I may have asked you - I know you were board certified in obstetrics - have you been board certified in anything else?

A. No.

Q. One of the things I learned from Dr. Ashmead is that he has a particular interest or specialization in reading ultrasounds and I'm wondering if you can compare your ability to read

ultrasounds with Dr. Ashmead. In other words, would you defer to him on a reading based on his subspecialization?

A. Without hesitation.

Q. Okay. And tell me, just so I can understand that, why is that? What is the difference in his training or experience from yours?

A. Well, he's had extensive training in ultrasonography, he's a fetal-maternal specialist, he leads the program here in ultrasonography and the training of our fellows and residents. I've known him a long time and respect his ability and I have no hesitation to call him any time I have a question, either on the phone, or when I was teaching here I would stop by and go over some case with him.

Q. I just had the opportunity to take Nurse Rhodes' deposition just before yours today and we were talking about the use of ultrasound to estimate fetal age and gestational age and she made a statement to me that it is more difficult to determine gestational age via ultrasound in the third trimester. Would you agree with that?

A. In general that's correct. The further into the pregnancy the less accurate is the estimated fetal

age.

Q. In terms of Dr. Ashmead's abilities, however, is he better able to utilize ultrasound to determine gestational age in the third trimester than, say, a generalist like yourself?

A. I would say yes, within the parameters of how difficult it is reading it, but certainly if -- I would say yes.

Q. In this case we're going to turn and look at some issue with respect to gestational age, but do you have any recollection of having reviewed the actual ultrasound films with respect to this particular patient?

A. No, I don't recall.

Q. And do you recall this patient at all, Gloria Maslanka?

A. The name seems to be familiar the one time I saw her and it's possible that I have taken care of her in the past.

Q. Okay. With respect to sitting here today and what you recall - that's what is important to me - in your mind's eye do you have a picture of what she looks like?

A. No.

Q. Okay.

A. I can't really say.
Q. And with regard to your recollection of her, other than what you've charted here do you have any recollection of any conversations that you had with her?
A. No, nothing specific. I would have -- at the end of the exam would have told her about ordering another ultrasound and I presume she asked me why, but I can't -- and I would have told her why, because of the discrepancy.
Q. Okay. And here you're telling me what your normal practice would be under the circumstances as opposed to what you specifically recall having happened?
A. Well, my practice would be to follow the recommendation of the ultrasonographer, which was to repeat the ultrasound.
Q. Sure. All right. Why don't we turn to the record and let's ask you some more questions about what happened here. The first record that I wanted to ask you about is this ACOG flow sheet.
MR. KULWICKI: And, Jim, do you mind sharing your copy?
MR. MALONE: No, I'm happy to do that. I've got marks on this. By showing it to the witness I

don't mean to surrender it as an exhibit. I assume that's all right.

MR. KULWICKI: That's fine.

MR. MALONE: I just want to make it clear.

MR. KULWICKI: Appreciate it.

Q. And, Doctor, as I look at this ACOG flow sheet there's an entry under the date July 26th. Does that appear to be your handwriting?

MR. MALONE: We're on a different page of it.

A. July 26th?

Q. Yes. Do you see that there?

MR. MALONE: Right here (indicating).

A. It's not initialed but that -- it may be my handwriting, I'm not sure.

Q. Fair enough. Let me ask you about how the McCafferty Clinic was run back in 2001. I've determined already that the two preceding visits were handled by nurse practitioners, a Kathy Poland and a Cathy Rhodes, and obviously you're an obstetrician. How is it that on prenatal visits sometimes the patients are seen by nurse practitioners and sometimes seen by an obstetrician?

A. If the obstetrician is there at each visit, unless

there's some reason that he's away, he would see the patient. We try to provide continuity of care. So we would try to see the patient at each visit if we could. If the patient comes in and we're not there or comes in for a visit that's not scheduled, she could be seen by either Kathy Poland, I believe was a Nurse Midwife --

Q. Oh, that's right.

A. -- and Rhodes is a Certified Nurse Practitioner.

Q. Correct. And in 2001, besides working at the McCafferty Clinic, did you work anywhere else in the hospital?

A. I taught. I taught medical students.

Q. Okay.

A. And I had residents, but I had no direct patient responsibility.

Q. When you taught residents, was that a didactic, like a classroom setting?

A. Yes, it was in the clinic, we discussed cases. And the students were first-year students, we introduced them to obstetrics.

Q. Did you deliver babies back in 2001?

A. No.

Q. With regard to this ACOG flow sheet, what was the purpose of this flow sheet?

A. Well, it's first to establish obstetrical history and then to begin prenatal care and provide prenatal testing and to follow the progress of the pregnancy.

Q. And in terms of prenatal care, I think you've pretty much covered it with that, but with respect to prenatal care what are the goals of prenatal care? Why do we do it or why do obstetricians schedule that?

A. First of all, to ascertain the status of the pregnancy, to ascertain the gestational age since that's important, obviously to establish the health of the mother, her previous prenatal history is very important, previous delivery history, and then to provide her with -- to provide the necessary prenatal testing, to eliminate any possibility of problems and to give her prenatal vitamins and other medication she may need.

Q. And why is it important to determine the gestational age during the prenatal period?

A. Well, it's important for two reasons. First of all, the patient will ask when the baby is due and you would like to give her a good estimation of that - before ultrasound we used to estimate size

and dates and correlate that with the last menstrual period - and obviously to determine if the patient is as far as she thinks she is.

Q. In speaking with Nurse Rhodes about half an hour ago, I understood that when a patient came in to the McCafferty Clinic and then presented at the hospital in labor at the L & D unit, that the McCafferty Clinic as a matter of course would send over portions of the chart to the hospital so that they could use all the prenatal information in the course of managing the labor and delivery. Is that --

A. I believe that's correct.

Q. Now, can you tell me what documents were sent from the McCafferty Clinic as a matter of course to the L & D unit when that happened back in 2001?

A. As far as I know the -- all of these pages would be sent in.

MR. MALONE: You have to tell him what pages you're indicating because the record will --

A. I'm sorry, well, the prenatal history, the physical examination and the flow sheet.

Q. Okay. Now, in this case we've got obviously Dr. Ashmead's July 12 ultrasound. Would that normally be sent from the McCafferty Clinic if it

was in their chart to L & D?

THE WITNESS: Is that the one I looked at?

MR. MALONE: Yes.

A. I'm not -- I'm not certain of the mechanics of how that ultrasound goes from our record to labor and delivery. I'm really not certain of the mechanics of that.

Q. Let me ask you a different question. Do you have any knowledge or recollection sitting here today as to whether or not in fact Dr. Ashmead's July 12 ultrasound report made its way to the L & D unit when Gloria presented -- or when Gloria was there in labor?

A. I honestly have no opinion on that.

Q. Now, looking again at the ACOG flow sheet under July 26, I appreciate you told us that you're not sure if that's your handwriting or not, but let me clarify. Can you rule out that that's your handwriting? In other words, can you say that that --

A. Let me see where my progress note would be. Sometimes I make a progress note and forget to sign the flow sheets.

Q. That's it right there (indicating).

A. That's it right there.

Q. Okay. Now, the fact that there's a progress note dated July 26, 2001, does that suggest to you that in fact you also filled out this column on the flow sheet?

A. I think that would be -- sometimes I put down the progress note and may forget to sign the flow sheet.

Q. Well, let's do this. Why don't we go through that column under July 26 on the flow sheet and just tell me what is charted there. Interpret it as best you can. If you don't know what something is or what it means, then tell me that as well.

The first entry under the fundus height, 31 centimeters --

A. Yes.

Q. -- what is the significance of that, Doctor?

A. Usually after 20 weeks of pregnancy the gestational age and the fundal height are sometimes correlated, so one would measure the fundus and get an idea of the gestational age. It's not a true measurement but it gives you roughly an idea.

Q. Can you tell me, assuming an estimated gestational age based on last menstrual period of, in this case it would be -- I note you didn't chart it

down here, that box is empty.

A. For some reason I did not write the fundal height.

Q. And do you know why you wouldn't write that down?

MR. MALONE: You wrote fundal height, you didn't write gestational age.

A. For some reason I may -- in talking to the patient, I can't remember, but normally I would put it in.

Q. All right. And then going down it looks like you charted the presentation as being vertex, correct?

A. Yes, sir.

Q. And then the fetal heart rate, is that Doptone?

A. Doptone, yes.

Q. And then the X there is the --

A. Is positive fetal movements.

Q. Got it. I'm sorry, I'm still on the fetal heart rate. You've got this cross there and in the lower right --

A. We divide the abdomen into quadrants, two upper quadrants, two lower quadrants, and this would have been in the left lower quadrant.

Q. And what did you chart in the left lower quadrant?

A. The presence of the heartbeat. I did not put the rate down. Sometimes I do. I don't usually do that unless I hear something unusual.

Q. So that's just a plus sign indicating that there is a fetal heart rate?
A. X, yes.
Q. I think the fetal movement is self-explanatory. Under the next box below that you've got a 0 with a line down and it looks like 0 at the bottom there.
A. Right, and those indicate -- I ask her questions about vaginal bleeding, any discharge, any cramping, any burning on urination, any increased pressure and to those she would have answered no.
Q. Okay. No charting under the box for a cervix exam. Does that mean that one was not done?
A. One was not done because it was probably not indicated.
Q. Blood pressure you've charted 93/53. Is that within normal limits?
A. Yes, in pregnancy it tends to be lower than normal parameters.
Q. You've got her weight at 151.6. Would that be a normal weight gain based on the July 12 entry of 147.6?
A. Let's see. That was what, two weeks before? A little generous, but a pound and a half a week we estimate. It depends on the patient.

Q. Is it enough to be a matter of concern or --
A. In the absence of normal -- in the absence of hypertension or -- it would not be of concern, no.
Q. And I think you were going to say in the absence of sugar in the urine?
A. Oh, yeah, the usual parameters.
Q. Which appears to be your next notation, you've got negative so you tested her urine to see if --
A. Yes, we test for usually glucose and albumin.
Q. Okay. Now, I don't see any further notes on that or signature. Why don't we turn to your progress note on the next page there, July 26, '01. It looks like the word "plan" is there; is that right?
A. Yes, I always write a plan for -- well, I usually write a plan, yes.
Q. And that appears to be your signature. Then the number down there, what does that reflect?
A. That's our hospital number, our physician number.
Q. And then, Doctor, if you would, just take me through the plan and tell me what those three items refer to.
A. Okay. On the basis of Dr. Ashmead's recommendation he ordered a repeat ultrasound I think in four to six weeks, so I did that,

scheduled it for the 20th, we had her sign tubal ligation papers and, because everything seemed to be normal, I had her come back in two weeks.

Q. Besides what we've looked at here, the ACOG flow sheet and this progress note, do you have any other notes that you're aware of that you charted with respect to this particular patient in this pregnancy?

A. No, sir.

Q. All right. Now, let's turn to Dr. Ashmead's ultrasound note and I can just show you mine for purposes of looking at this. I'm looking at the July 12, 2001 ultrasound by Dr. Ashmead and in the lower right-hand corner there's an initial there. Does that appear to be your initial?

A. Yes, sir.

Q. And would that signify that you saw that ultrasound report and reviewed it?

A. I saw it and reviewed it, yes, sir.

Q. And it appears based on your progress note that you were aware of it as of July 26th because you made a note that we need to get another ultrasound, right?

A. Based on his recommendation, yes.

Q. Okay. Now, Doctor, I was talking to Nurse Rhodes

just before your deposition and she told me that in her practice it's routine that if she gets an ultrasound that she would chart the results of that ultrasound in the ACOG flow sheet up here where it says ultrasound. Do you see that there?

A. Yes, uh-huh.

Q. Was that your practice back in 2001 as well?

A. I did not since I had the hard copy of the ultrasound. I used that as opposed to putting it in there.

Q. But what I'm getting at here is that in that ultrasound there's a discrepancy between the gestational age, as you know, and the gestational age based on periods that's charted in the ACOG flow sheet. And if you don't chart the results of the ultrasound or chart the discrepancy here, how does that information get sent to L & D when she presents for labor and delivery?

A. I think the ultrasound is available to labor and delivery when a patient comes in.

Q. Okay.

A. I believe.

Q. In 2001?

A. Again, the mechanics of how all this gets transferred to labor and delivery I cannot state

for certain.
Q. Okay.
A. There is a way of getting it altogether there because they have a chart that they start on labor and delivery.
Q. And let me just ask you back in 2001 when there would be a discrepancy between gestational age based on periods and an ultrasound like the one Dr. Ashmead performed, is that a significant fact or a significant development in the course of the prenatal evaluation?
A. I don't understand.
Q. Well, the last estimated date is 31 weeks and she comes back two weeks later for the visit that you're involved with and at that time it's reported that it wasn't 31 and 5/7 weeks per periods, but per ultrasound it's noted as being 24 and 1/7 weeks. Is that a substantial discrepancy?
A. A discrepancy and that occurs oftentimes when a patient registers late for her first prenatal visit.
Q. How do you resolve that or how would you resolve that as an OB who is handling a patient's prenatal care back in 2001, that difference?
A. One would get a follow-up ultrasound and compare

the growth between the 12th of July and then the next ultrasound.

Q. In 2001 presented with this conflict in information a difference of roughly seven weeks based -- over seven weeks, would you normally go by the ultrasound or the periods as a working sort of parameter or a working benchmark for care of the patient?

A. Ultrasound done on the third trimester of pregnancy is not terribly accurate, it gives you an indication. The last menstrual period of a patient sometimes is the most inaccurate part of her history although you like to use that as a beginning point. When a discrepancy occurs then you also would check the fundal height to see if that was reasonable. So we use a lot of parameters, the fundal height, the last menstrual period, the ultrasound.

Q. Let me make sure I heard you correctly. I think you said that the last menstrual period is often the most inaccurate part of a patient's history?

A. In some patients' history, correct. We use that a lot and some patients are of course very good about it. The problem is, of course, depending if the patient was on oral contraceptives, which

would sometimes make a difference.
Q. And there could be other factors too?
A. Many factors, right, irregular periods.
Q. Light period after pregnancy?
A. Right. So we start there and from that calculate the estimated date of confinement by subtracting three months and adding seven days.
Q. Now, you know, since you didn't chart on the flow sheet what you considered her gestational age to be, based on the information that you have here today, in other words, what the last menstrual period was believed to be and what Dr. Ashmead found on July 12 by ultrasound, can you for us today figure out what you would have likely put in there if you had filled it out?
A. I can't possibly remember. I did not record that even though I probably considered it, but I just didn't have it in there.
Q. Would you -- Go ahead.
A. And a lot of times I may not put it in possibly because there's some discrepancy on the date and I don't want to put something down because we're going to go ahead and get a follow-up ultrasound. That may be the reason rather than just going in and following 30, 31, 32 weeks.

Q. Do you think that an obstetrician at the L & D unit at MetroHealth in 2001 who looked at this sheet would determine based on that being not filled out that the date was uncertain? Do you think that would be something that they should know?

MR. MALONE: Well, objection. I guess you're asking him to read somebody else's mind.

MR. KULWICKI: I'm trying to ask him in terms of practices.

MR. MALONE: You can ask the question. I'm just trying to make a record.

A. Not necessarily. Because they go ahead and examine the patient and do measurements and whatnot. So that would -- may or may not be helpful. I don't think so. I mean not necessarily.

Q. Would you agree that knowing what we know here, that we've got these dates by periods and then we've got the dates by ultrasound, would you agree that the date of her -- the gestational age and estimated date of delivery were both uncertain as of July 26th?

A. I would think so because there's such a discrepancy in that, the dates and the ultrasound.

Q. Would that be important information to convey via the record to the obstetrician who is going to deliver the baby that the dates are uncertain?
A. I would think they would have access to the ultrasound to go ahead and make the determination. I would think. I don't know.
Q. But just a different question, which is would it be important to convey the estimated gestational age as determined during the prenatal period to the obstetrician that's going to manage the labor?
A. Not if one is not certain of the date.
Q. Okay. Well, and that raises a better point, which is would it be important to convey to the obstetrician who is managing labor that the gestational age is uncertain or unknown?
A. I don't know how to answer that since I would have no direct contact with labor and delivery unless I called them or discussed it with them.
Q. Well, but you would communicate with them via the prenatal record, correct?
A. Yes.
Q. And you didn't specifically chart down here that the gestational age was unknown, correct?
A. I didn't specifically chart that, no, because I ordered a follow-up ultrasound based on the July

12th ultrasound. So I may not have felt comfortable putting down an estimated gestational age. It may have been -- well, I just wasn't certain of it perhaps. When was her last period?

Q. I think it's over here actually.

MR. MALONE: It's at the top of that page.

A. November 30th, so she would have been due September 7th, I think, if we go by that, minus three months plus seven days. I don't have a gestational wheel. But supposedly --

Q. Here you go.

A. Okay. Last menstrual period November 30th. It's been a while since I looked at this wheel. November 30th --

MR. MALONE: I think the 9-7 date would relate to the 12-25 period, not the 11-30 period.

A. Right. Let's see. So that's scratched out?

MR. MALONE: Yes. What was the question again?

Q. Let me ask you, Doctor, I mean based on -- based on the last period of 11-30-2000, what would be the estimated date of delivery?

A. September 6th or 7th.

Q. Okay. And that's what they wrote here.

A. Okay.

Q. I don't know if you saw that.
A. I didn't -- I saw it but I didn't remember it. I wanted to calculate it myself.
Q. And based on your progress note of July 26th, you've got her coming back August 20th for another ultrasound, right?
A. We scheduled it for that date, I believe. I think it said six weeks after the initial one.
Q. Now, on July 26th certainly it's possible that a patient will come back before that scheduled ultrasound, the August 20th ultrasound in labor? I mean women go into early labor frequently, don't they?
A. Well, they go in. Supposedly not frequently but 10 percent of the time.
Q. 10 percent, okay.
A. They can go in early, let's say, depending on the patient's history and everything.
Q. I mean don't you think it would have been the careful thing to do to report that you could not determine gestational age and chart the ultrasound findings up here? Don't you think that should have been done?
MR. MALONE: Objection. You're asking him two questions. Go ahead.

A. Many times I'll put stuff in my progress note which I don't put in my flow sheet. I'm presuming I didn't put it in because I was uncertain of what to put down as the -- what does it say, estimated? Weeks of gestation best estimate, yeah, I perhaps did not feel comfortable putting down a date, a best estimate because of the discrepancy.

Q. Well, let me ask did you not feel comfortable writing down the results of the ultrasound?

A. I usually don't put it there because I have the hard copy in the chart.

Q. But did you know in 2001 that the McCafferty Clinic did not send over the hard copy of the ultrasound reports to the L & D unit when a patient presented in labor?

A. That I'm not sure. I presume that's all -- you know, I'm not sure of that. I can't answer that.

Q. Sure. Fair enough. Now, Doctor, there's another copy of this ultrasound report, the July 12 ultrasound report, and this one shows that you pulled it up to review it in March of 2002, so roughly not quite a full year later, but six, seven, nine months after this baby was born it looks like you pulled up a copy of this ultrasound to look at it. Do you remember why you did that?

A. No.
Q. And let me make sure I'm reading that correctly. It says reviewed by and then it's got your name and then it says reviewed on and it says March 1 of 2002. Does that tell me that you pulled this up in some fashion to look at it?
A. That's what it looks like but I don't know why I would have done that. March of 2002.
Q. You weren't caring for the patient at the time, were you, in March of 2002?
A. Unless I was seeing her as a GYN patient.
Q. We've got the McCafferty record. I don't see any record of it.
A. No, there would be no reason. I don't know the answer to that.
Q. Do you remember this case in the sense that something bad happened, obviously the child was substantially younger than was understood at the time of labor and delivery? Do you remember that happening, that the baby was born prematurely?
A. No.
Q. Okay. Well, stepping back for a second from your responsibilities but looking at the picture as a whole, you've got a young lady who comes in, she's getting prenatal care, albeit late, and there's a

discrepancy in her dates, her gestational age. Do you think that as a whole MetroHealth should have in place a system for making sure that that information in 2001 was available in the event that patient presents for labor and delivery?

A. I can't answer that because I don't know the mechanics involved.

Q. Well, but just in terms of care of the patient would you agree that it's -- that accepted standards of medical care in 2001 dictated that a patient whose dates are unknown, that that information is conveyed to the folks that are managing her delivery or her labor?

MR. MALONE: I'll state my objection again. He's answered the question that he can't answer. He doesn't know the mechanics.

Q. You can answer.

A. I don't know the mechanics of how information -- I know information is transferred from our clinic to labor and delivery, at certain times the lab work also is available, but I don't know the mechanics of it.

Q. All right. Well, let me jump ahead to labor and delivery. Was there a time after 1991 when you actually did deliver babies here at MetroHealth?

A. No.
Q. Okay. Prior to coming to MetroHealth where did you deliver babies at?
A. In Lorain, Ohio.
Q. At --
A. Saint Joseph Hospital.
Q. Saint Joseph's. When a patient there of yours presented for labor and delivery, did you make an effort to determine the estimated gestational age of the baby at the time of labor?
A. My patient?
Q. Yes.
A. All the information was already in her chart and all of her labs, all of her ultrasounds. Since it was all done at Saint Joseph Hospital it was incorporated into her chart or sent from my office to the hospital.
Q. On page two of Dr. Ashmead's ultrasound report, his comment section, he recommends that another ultrasound be performed and there's some circling around that. Does that appear or can you tell me that in all likelihood since your initials are on the front page, is that likely you circling that information to highlight the fact that she needs to come back in six to eight weeks for another

ultrasound?
A. Since I did not initial this, I --
Q. And if you don't know, that's okay.
A. I don't know for sure. I would say that that would -- I did that to emphasize the fact that I wanted to get it done for two reasons, the dates and also to follow the kidney. So I presume that's my circling.
Q. All right. But at least in your private practice before you came to MetroHealth, practicing within accepted standards of medical care, you made sure before you delivered a baby that you knew the gestational age of the baby, right?
A. It's my patient and I would follow it, certainly.
Q. Okay. And that would be something that would be an important thing to know for the obstetrician delivering a baby, right?
A. In a private practice you know your patients because we've been following them for a long time, so the information when she comes to labor and delivery is pretty current, it's in our mind, it's recorded so you know the patient a lot better.
Q. But setting aside the -- setting aside the nature of a private practice versus the type of practice that there is in the clinic setting with

MetroHealth, focusing on the quality of care, would you agree that in terms of quality of care it was important for the obstetrician and you while you were in private practice to know the gestational age of the baby when a mom presented in labor?

A. I would say yes.

Q. And in terms of your training residents here at MetroHealth, would that be something that you would convey to them; in other words, convey to them that when a mom presents in labor you have to go through a checklist of things and one of those things you want to determine is what is the gestational age of the baby to determine whether this is a baby that's ready to be delivered or this is early labor that needs to try to be prevented?

A. Based on the information that's available, the examination of the patient becomes an important part of that, to correlate the examination with the information, the dates, and one of the things we try to stress or my chief always stressed is to measure the fundal height when the patient comes in.

Q. But also to review the ACOG flow sheet to look --

A. Oh, if it's available, absolutely.
Q. And part of the reason that you trained residents here at MetroHealth to look at the ACOG flow sheet was to determine the gestational age of the baby, right?
A. (Witness nodded head up and down.)
Q. Yes?
A. Yes, I'm sorry.
Q. Because that would be part of the standard of care that you're teaching them to practice within; true?
A. Yeah, because of the system the patients are followed in the various clinics and when they come in they're being followed by the in-house staff.
Q. Would you agree that it would be below accepted standards of medical care for someone, an obstetrician to deliver a baby when a mom presents in labor without first making an effort to determine the gestational age?
MR. MALONE: Objection.
A. I don't --
MR. MALONE: You know he's retired.
MR. KULWICKI: I know that.
MR. MALONE: He can't testify to these things.

MR. KULWICKI: I'm not sure about that.

MR. MALONE: Well, I am, but I'll let him answer the question for you. But you guys like to use that so we're going to use it. Do you understand his question?

THE WITNESS: No.

MR. MALONE: Why don't you ask it again or re-read it to him.

MR. KULWICKI: I'll re-ask it.

Q. Let's talk about Gloria Maslanka. Gloria shows up in August of 2001 at the L & D unit, she's in labor.

MR. MALONE: That's not true, David. She came July 31st.

MR. KULWICKI: I'm sorry. Thank you.

Q. She arrives at the L & D unit July 31st of 2001. Would you agree that it would be below accepted standards of care for obstetricians at MetroHealth to induce labor -- or to augment labor and attempt to deliver the infant without attempting to resolve the uncertainty of the baby's gestational age?

MR. MALONE: Well, show an objection. Labor was not induced in this case.

MR. KULWICKI: I corrected myself.

MR. MALONE: Well, I don't know how it will read. That's all.

MR. KULWICKI: Okay.

A. I can't answer that the way you asked it.

Q. Okay. All right. When does a multip typically feel movement of the baby?

A. Multip of course is usually more aware of movements because of previous pregnancies. Somewhere between 18 and 20 weeks. It could be a little earlier. Other factors of course depends on the apprehension or anxiety of the patient to feel movement because once they feel movement they feel more sure about it. We say 20 weeks, halfway through the gestational age, but it could be as early as 18.

Q. And how does that compare with a primip?

A. Primigravida, probably closer to 20 weeks. Because of the various changes going on in the body they may not always be aware of movement, and of course again a lot of them anticipate it because they're anxious for movement realizing that that's the health of the baby. But 20 weeks, plus or minus, is thought to be the time that one would probably anticipate feeling it.

Q. When you have a patient where the gestational age

of the baby is unknown in a prenatal setting, do you typically go through sort of a detailed history to try to get a better idea about the period, the last menstrual period?

A. Try to.

Q. Okay. And what kind of things do you want to know?

A. Well, you ask them are they sure about the last menstrual period, have your periods been regular, have you been missing periods, was it a normal duration of the period, were you on birth control pills or had you stopped birth control pills. There are many factors.

Q. Now, in your practice when you would go through this detailed history with respect to last menstrual period, did you typically chart that down, what your discussion was? Is that something you would usually write out?

A. I usually have a -- I can't think of the word, but a list of things that I ask because some people are very certain of their period, which is fine, and you go through. Others are not certain and you want to find out what's not certain. So I don't record every little detail but I do know that I go over that.

Q. But do you usually chart something to reflect that you went through that with the patient, that history of last menstrual date?

A. Once I marked down -- once I go through that then I would mark down what the last period was.

Q. Doctor, we went through your progress note and your plan, those three items listed there. Besides those three items, do you recall discussing anything else with Gloria Maslanka?

A. To sign the tubal papers, I'm sure we discussed the discrepancy in the dates because of the ultrasound and my reason I ordered the repeat ultrasound.

Q. Do you have a recollection of discussing that?

A. No, I can't give you the exact wording but I'm sure it was discussed because I would not have ordered another ultrasound without explaining to her why I was doing that.

Q. In 2001 did the hospital typically call you to report that one of your prenatal patients was presenting for labor and delivery?

A. Not unless I had sent a patient in for evaluation and they would give you a feedback. But if a patient came in I would not know about it.

Q. And I assume you didn't have any involvement in

the labor and delivery, management of labor and delivery here, correct?

A. No, sir.

Q. Now, we were talking about mechanics of getting information regarding prenatal testing and assessment to the L & D unit and you, I think, told us that you weren't aware of what those mechanics were?

A. Exact mechanics, no.

Q. I understand that. But was it your expectation that the results of that ultrasound in July of 2001 would be available or somehow communicated to the L & D unit so they had that information when she presented?

A. I can't answer that specifically, no.

Q. Well, do you think it would be important for the folks managing her labor to know what the results of that ultrasound were?

A. It would be and that record should be available to someone by accessing -- since it was on Epic.

Q. This is pre-Epic.

MR. MALONE: This is not on Epic, Doctor. This predates Epic. This is four and a half years ago.

THE WITNESS: I was going to ask you about

that. Excuse me.

MR. MALONE: That's all right.

A. Epic came in -- it must have been '02 then because I had --

Q. Right.

A. Well, then, no, I don't know how to answer that except to ask if there was an ultrasound available, they would then access it in the ultrasound department unless they sent -- I don't know. I can't answer that because I don't know the mechanics of whether they send stuff only to us and then we transmit it to them. I can't answer that.

Q. The fundal height measured on July 12 is 30 centimeters and the gestational age by ultrasound was 24 and 1/7 weeks. Are those numbers consistent with each other, 30 centimeters and --

A. Fundal height of course can be -- can vary depending on the patient's habitus, if she's obese, which she was not. If it's measured -- according to how we're taught to measure it from the top of the symphysis to the top of the fundus, but one has to be careful because the fundus many times will rotate to one side or the other, so one may not be measuring it correctly. If it's bigger

than the dates one would think about the size of the patient, but she's only 151 pounds. Of course there would be other factors, of course, the baby, there could be excessive fluid which would give you --

Q. Let me ask you, is that 30 centimeters bigger than that date, 24 and 1/7 weeks?

A. I'm sorry, would that be bigger?

Q. Yes.

A. Yes, 30 centimeters, and she was how many weeks?

Q. 24 and 1/7 weeks.

A. 1 or 2 centimeters probably would be in the range. Again, we try to consistently measure the fundal height consistently, we do the same thing, we try to do the same thing each time. There is some variation between what we call inter-observer observation, two different people measuring it. One would depend on the skill of the examiner, the fundal height could change because of other reasons.

Q. Doctor, do you still reside in Cleveland?

A. No, I live in Avon Lake.

Q. Okay. And any plans to move in the next year or so?

A. No, sir.

MR. MALONE: I'm only laughing because he was talking about going to Phoenix in retirement.

THE WITNESS: That was last year.

MR. KULWICKI: Off the record.

(Discussion was had off the record.)

A. No, as far as I know I do not plan to move.

Q. Ms. Maslanka was being treated prenatally for Group B strep colonization, I believe. As of your visit July 26th, did that problem appear to be resolved based on what we have here in the record?

A. Usually the treatment for Group B strep is one hundred percent effective, so we don't retest.

Q. In terms of your visit with her, did you see any signs of infection or any other abnormalities?

A. I can't state for sure. Whatever I have listed there, I would have made a note of it.

MR. KULWICKI: Okay. Well, Doctor, that's all I have. Thank you for your patience with me and appreciate your time here. Thanks.

MR. MALONE: Tell this young lady where you would like your transcript sent, because you get to read it and make any corrections that you think need to be made. She'll send you an explanatory note. Give her the address so that she has the mailing address.

THE WITNESS: 324 Champions Court, Avon Lake, Ohio 44012.

(Whereupon, signature was not waived by the witness.)

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(The deposition was concluded at 11:15 a.m.)

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W I T N E S S C E R T I F I C A T E

I, Joseph Sciarrotta, M.D., hereby certify that I have read my deposition taken on January 11, 2006, in the case of Gloria Maslanka, Individually and as Parent and Natural Guardian of Shane Maslanka versus MetroHealth Medical Center, consisting of forty-five pages, and that said deposition is a true and correct transcription of my testimony.

_____
Joseph Sciarrotta, M.D.

Dated this _____ day of _____, 2006.

Sworn to and subscribed before me this _____ day of _____, 2006.

_____
Notary Public

My commission expires _____.

STATE OF OHIO,)
)
SUMMIT COUNTY.)

I, Christine Leisure, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named Witness, Joseph Sciarrotta, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony so given by him was by me reduced to Stenotype in the presence of the witness, and that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid.

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

I certify that I am not a relative of, employee of or attorney for any of the parties in the above-captioned action, that I am not a relative of or employee of an attorney of any of the parties in the above-captioned action, that I am not financially interested in this action, and that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Fairlawn, Ohio, on this 17th day of January, 2006.

Christine Leisure

Christine Leisure, Notary Public
My commission expires April 22, 2007.

Maslanka vs. MetroHealth Medical Center
Deposition of Joseph Sciarrotta, M.D.