

**IN THE CIRCUIT COURT OF DESOTO COUNTY, MISSISSIPPI**

**MONICA WREN, as Guardian,  
Mother and Next Friend of S.J.D., a minor**

**PLAINTIFF**

**vs.**

**CAUSE NO: CI2020-399GCD**

**DABNEY HAMNER, M.D.; METHODIST  
LEBONHEUR HEALTHCARE a/b/a  
SOUTHCREST WOMENS HEALTHCARE;**

**DEFENDANTS**

**DEFENDANTS' DESIGNATION OF EXPERT WITNESSES**

NOW COME the defendants, Dabney Hamner, M.D. and Methodist LeBonheur Healthcare d/b/a Southcrest Womens Healthcare, by counsel, and designate the following persons to be called as expert witnesses at trial. This response is also intended to serve as supplementation of any outstanding discovery requests regarding expert witnesses.

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In addition to the persons mentioned above, the defendants reserve the right to call any witness designated as an expert by another party for the purpose of presenting the testimony for which the witness was originally designated.

The defendants further designate those healthcare providers identified in the records of Monica Wren and S.J.D., a minor. These providers are not retained experts and, if called, would be expected to provide testimony consistent with their entries in medical records.

**SUMMARY OF FACTUAL DATA**

What follows is merely a summary of the content of medical records pertaining to Monica Wren and S.J.D., a minor. The expert witnesses mentioned above will refer to this data and they reserve the right to rely upon and testify about any and all information contained in medical records produced through discovery and/or depositions and other documents reviewed and relied upon by the experts.

Monica Wren, a 30 year old gravida 3, para 2, presented to Southcrest Womens Healthcare as a new OB patient on May 10, 2016. Ms. Wren stated that the date of her last menstrual period was February 15. She was 5' 7" tall and weighed 345 pounds with a BMI of 67. Vital signs were stable and the physical examination performed by Dr. Hamner was within normal limits to include the pelvis and the bony pelvis. Laboratory studies included a hemoglobin A1C test, urinalysis and a pregnancy test which was positive. Ultrasound examination for dating was consistent with menstrual dating and an EDD was entered as November 15, based on menstrual dating and

November 12, based on ultrasound dating.

Ms. Wren's pregnancy history revealed that, on May 20, 2014 she gave birth at 40 weeks to a male child who weighed 8lbs 7oz. This was a vaginal delivery and she reported that she experienced GDM during this pregnancy which was controlled with diet. Ms. Wren delivered her second child on April 1, 2015, also at 40 weeks gestation. The male infant weighed 7lbs 7oz and was delivered via vaginal delivery. No complications were reported with regard to the second pregnancy.

Ms. Wren was given an appointment to follow up in 3 weeks. In the meantime she was called on May 16, to report that her lab tests revealed anemia and a prescription for an iron tablet was provided. The elevated H<sub>1</sub>C result was called to Ms. Wren on May 19, and she was scheduled for a 3 hour oral glucose tolerance test in the office on May 31. She was reminded not eat or drink after midnight prior to the OGTT.

Ms. Wren did not return to Southcrest for her second OB visit until June 13. She had no complaints at the time. Her weight had increased to 348 lbs. A quad screen and an oral glucose tolerance test were administered. The quad screen was negative. The OGTT result was 209, well above laboratory norms. Ms. Wren was asked to attend a diabetes class and return to the clinic in 1 month. Ms. Lou Brown, NP saw Ms. Wren on this date.

Ms. Wren did not return until July 18, at 22 weeks, 6 days. She had no complaints. Her weight was 352 lbs. She reported that she had not attended the diabetes class which had been scheduled for her and so the class was rescheduled. An ultrasound examination was performed. Finger stick glucose level was 125, again above the laboratory norms. A diagnosis of gestation diabetes (GDM) was entered in the chart. Care instruction materials were published to the patient

portal. Urinalysis testing was performed. Three week follow up was scheduled. Ms. Wren was seen by Ms. Brown on this visit.

Dr. Hamner saw Ms. Wren in the clinic on August 8 at 25 weeks, 6 days. She reported having attended a class with the dietician and also stated her desire for a bilateral tubal ligation. Finger stick glucose level was 104, WNL and Wren reported having normal blood sugars at home. Urinalysis revealed the presence of a UTI and, on August 15, Wren was called with the results of this study and Keflex was ordered. Ms. Wren was asked to return in 3 weeks.

Dr. Hamner saw Ms. Wren again on August 29. At this time she was at 28 weeks and 6 days gestation. Finger stick glucose on this occasion was elevated at 232 and Glyburide, a medication for diabetic control, was ordered. The patient weighed 350 lbs. Her blood pressure was initially recorded at 143/87, but when repeated was 120/72. Urinalysis was WNL and Wren was asked to return in 1 week.

Ms. Wren did not return to the clinic until September 14. At that time she was again assessed by Dr. Hamner who noted that a random blood sugar was again elevated at 203. Noting that this was her second significantly elevated blood sugar Dr. Hamner recommended hospital admission for diabetic control and he also asked Ms. Wren to return to the clinic in one week. Ms. Wren was scheduled for a non-stress test, biophysical profile, ultrasound estimate of fetal weight and possible hospital admission.

On September 23, Ms. Wren was called to inform her that her UA revealed a UTI and a prescription for Macrobid, an antibiotic, was provided.

Also on September 23, Dr. Hamner's office was notified that Ms. Wren had not gone to the hospital as requested. She did not return for her one week follow up visit as requested.

Ms. Wren came back into the clinic on October 5, 2016 where she was seen by Dr. Hamner. At this point she was noted to be at 34 weeks. Dr. Hamner made note of the patient's non-compliance in that she had not presented to the hospital for testing as requested. Wren explained that she could not be hospitalized as she had no babysitter. Random glucose level was high at 114. Urinalysis, hemoglobin and hematocrit testing was performed and Dr. Hamner referred Ms. Wren to the labor and delivery unit for testing.

On October 5, Ms. Wren was seen in the labor and delivery unit at BMH-DeSoto where she underwent a biophysical profile resulting in a score of 8/8. She had a 24 hour urine protein test run. She also underwent an ultrasound for assessment of gestational age and for assessment of fetal weight. Estimated ultrasound gestational age was 36 weeks, 3 days  $\pm$  2 weeks and 4 days. EFW was 3009g  $\pm$  451.35g (6lbs, 10oz  $\pm$  1lb, 0oz). Estimated fetal growth percentile was greater than 97.

Ms. Wren returned to Southcrest on October 12. She was attended by Dr. Hamner who discussed the results of her recent ultrasound, BPP and 24 hour urine testing. Also discussed were cultures needed at the following visit. A fetal non-stress test was reactive/reassuring and a random glucose level was again high at 117. A diagnosis of mild preeclampsia was entered in the record and Labetalol was ordered for blood pressure control. Clinic records also reveal that an attempt was made to contact Ms. Wren on this date to discuss NSTs to be performed in the office and NSTs/BPPs to be performed at the hospital if the office NST was not reassuring/reactive.

Ms. Wren returned on October 18 and she was seen by Ms. Brown. At that time her BP was noted to be 148/95. Random glucose level was 126. Fetal NST was not reassuring. On this occasion Ms. Brown discussed the development of mild preeclampsia with Ms. Wren and referred her to the labor and delivery unit at Baptist for additional testing.

Ms. Wren was admitted to the labor and delivery unit at BMH-DeSoto on the 18<sup>th</sup> where she underwent a biophysical profile with a score of 4/8. Estimated fetal weight via US was 3851g  $\pm$  577.61g (8lbs, 8oz  $\pm$  1lb, 4oz). Average ultrasound age was noted to be 38 weeks and 2 days.

A second biophysical profile was performed on October 19, in follow up to the previous day's testing. On this occasion the BPP score was 8/8.

Ms. Wren returned to Southcrest on October 25, and she was seen by Dr. Hamner. Gestational age was noted to be 37 weeks. NST was reactive and a random glucose level was WNL at 48. A urinalysis was obtained and vital signs including a BP of 145/99 were noted. Macrobid was prescribed. Per examination Ms. Wren's cervix was stated to be fingertip dilated/thick. The fetus was at -4 station and presenting in a vertex position. On this occasion Dr. Hamner discussed induction of labor at 38 weeks and explained the risks and benefits of same to Ms. Wren. Ms. Wren gave her informed consent to undergo induction of labor and she was called later with instructions regarding the process.

Ms. Wren was admitted to BMH-DeSoto on October 30, for cervical ripening and induction of labor.

Dr. Hamner examined Ms. Wren on the morning of the 31<sup>st</sup> and noted an EDD of November 15, with a gestational age of 37W, 6D. He noted that Ms. Wren had developed gestational diabetes and that she had been relatively non-compliant. Dr. Hamner stated that her BP had been elevated recently and that a 24 hour urine test revealed proteinuria leading to a diagnosis of mild preeclampsia. He also noted that ultrasound examination had suggested an infant thought to be large for gestational age. On physical examination Wren was noted to be dilated 1 cm, 50% effaced at -3 station with membranes intact and presenting vertex. Fetal heart rate tracing was reassuring.

Induction progressed throughout the day and the fetal heart tones were monitored electronically. The nurses maintained continuous notes regarding the fetal heart rate tracing, the progress of cervical dilatation and the presence and status of contractions. The fetal heart rate tracing was consistently assessed as Category I by the nursing staff. A Category I tracing is a reassuring finding. Labor progressed well and at 1705 Dr. Hamner examined Ms. Wren and found that her cervix was completely dilated. There were no abnormalities of labor were encountered.

Nurses' notes indicate that the fetal head delivered at 1723. The fetus presented in the O/A position and shoulder dystocia was recognized. A gentle attempt at traction failed to resolve the dystocia. Multiple hospital employees were available to assist with the delivery. Ms. Wren was placed in the McRoberts position and supra pubic pressure was applied by the nursing staff. Dr. Hamner rotated the anterior shoulder to accomplish delivery. Delivery time was 1725.

Apgar scores were 3/7/8. The infant weighed 10lbs 15.3oz or 4970g. Care for the child was assumed by the Neonatal Nurse Practitioner. A perineal laceration was repaired and Ms. Wren was sent to the floor.

The infant, SJD, was admitted to the nursery where she was noted to be pink, with lungs CTA. Heart sounds were normal and peripheral pulses were palpable. Good peripheral perfusion was noted. Tone and activity were stated to be normal for age. Absence of movement in the right arm was noted, but the child did move her fingers. The infant was seen by a cardiologist. SJD continued with no movement of the right arm and shoulder resulting in a diagnosis of Erb's Palsy. X-rays ruled out fractures. SJD was discharged on November 4, to follow up with physical therapy and with Dr. Chase, a cardiologist.

Since that time, SJD has received physical therapy and occupational therapy. She has been



followed by a cardiologist, a neurologist and an orthopedist, all as more thoroughly discussed in the child's medical records.

This the 21<sup>st</sup> day of September, 2021.

UPSHAW, WILLIAMS, BIGGERS  
& BECKHAM, LLP

/s/ Tommie Williams

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**CERTIFICATE OF SERVICE**

I, Tommie Williams, of counsel to Defendants, Dabney Hamner, M.D. and Southcrest Womens Healthcare, do hereby certify that a copy of the above and foregoing pleading was this day forwarded to all counsel of record by depositing a copy of same via:

|                          |                    |                          |                |
|--------------------------|--------------------|--------------------------|----------------|
| <input type="checkbox"/> | United States Mail | <input type="checkbox"/> | Certified Mail |
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| <input type="checkbox"/> | Email              | <input type="checkbox"/> | Overnight Mail |
| X                        | MEC System         | <input type="checkbox"/> |                |

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SO CERTIFIED, this the 21<sup>st</sup> day of September, 2021.

/s/ Tommie Williams  
TOMMIE WILLIAMS

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Dr. Hamner practices Obstetrics and Gynecology in DeSoto County, Mississippi. After graduating from the University of Mississippi Dr. Hamner attended and completed medical school at the University of Mississippi Medical Center in Jackson in 1988. He then successfully completed a residency in obstetrics and gynecology at Tulane University Hospital and its affiliated clinics in New Orleans. Dr. Hamner is board certified in obstetrics and gynecology and he has practiced in DeSoto County since 1998. Dr. Hamner's curriculum vitae is attached as Exhibit 1.

By virtue of his medical education, training and experience, Dr. Hamner is familiar with the standards of care which prevailed in the practice of obstetrics in 2016 with regard to patients presenting as did Monica Wren. He has experience in the treatment of pregnant patients presenting with diabetes, obesity, gestational diabetes and preeclampsia. He has experience in dealing with the obstetrical emergency known as shoulder dystocia. He has experience in the use of ultrasound in pregnancy. Dr. Hamner is, therefore, qualified to provide opinion testimony as an expert in the field of obstetrics and gynecology with regard to the issues presented in this case.

In addition to his personal encounters and experience with Ms. Wren, Dr. Hamner has reviewed and will rely upon the following medical records and related documents in offering his testimony and opinions in this case:

Medical Records:

- Southcrest Womens Healthcare - Monica Wren
- Baptist Memorial Hospital DeSoto - Monica Wren
- Baptist Memorial Hospital DeSoto - S.J.D., a minor

Depositions:

- Dabney Hamner, M.D.
- Monica Wren
- Joyce Wren

Miscellaneous:

- Pleadings identifying the plaintiffs' experts including Dr. Hugh M. Ehrenberg.

Dr. Hamner will also review and testify regarding medical records, medical literature and/or depositions produced after the date of this pleading.

The facts which form the bases of Dr. Hamner's opinions are contained in the medical records and depositions mentioned above. Those records and depositions are incorporated herein by reference. Dr. Hamner reserves the right to comment on any and all of the data contained in the records and depositions.

Based upon his medical education, training and experience Dr. Hamner will opine that the care he provided to Monica Wren was reasonable, appropriate and was provided in accordance with standards of care in the practice of obstetrics. Dr. Hamner will respond to and refute the allegations attributed to Dr. Hugh M. Ehrenberg.

Dr. Hamner will explain that shoulder dystocia is often defined as a delivery that requires additional obstetric maneuvers following failure of gentle downward traction on the fetal head to affect delivery of the shoulders. Retraction of the delivered fetal head against the maternal perineum (turtle sign) maybe present and may assist in the diagnosis. Shoulder dystocia is caused by the impaction of the anterior fetal shoulder behind the maternal pubis symphysis. Shoulder dystocia is most often an unpredictable and unpreventable obstetrical emergency. Failure of the shoulders to

deliver spontaneously places both the mother and child at risk for serious injury.

Various risk factors have been described in association with shoulder dystocia and neonatal brachial plexus palsy (NBPP). They include maternal obesity, fetal malposition, labor induction, labor abnormalities, operative vaginal delivery, fetal macrosomia and prior shoulder dystocia. However, except for a history of a prior shoulder dystocia, these risk factors have not been shown to be statistically significant or clinically useful predictors of the occurrence of SD or NBPP. Most NBPP cases occur in women without known risk factors. Risk factors for shoulder dystocia are not reliable predictors for its occurrence.

Once shoulder dystocia develops, the primary objective is to deliver the fetus before he/she suffers a hypoxic ischemic brain injury. A series of obstetrical maneuvers have been developed over the years for use in response to shoulder dystocia. The maneuvers employed in this case (McRoberts maneuver/supra-pubic pressure/rotation of the anterior shoulder-Woods screw maneuver) are recognized, approved and widely used obstetrical maneuvers when confronted with shoulder dystocia.

NBPP, to include an Erb's palsy such as is described in S.J.D.'s medical records, can occur in several ways. Maternal forces of labor alone are a known cause of NBPP. Further, properly applied obstetrical maneuvers can result in NBPP. There is no high quality or consistent data available to suggest that NBPP is caused only by the application of excessive exogenous force (physician applied) and/or excessive force applied in an inappropriate direction. The existence of a brachial plexus injury following shoulder dystocia does not suggest that inappropriate exogenous force caused the injury.

Dr. Hamner and his associates at Southcrest Womens Healthcare provided reasonable and

appropriate prenatal care for Monica Wren. Risk factors for macrosomia including maternal obesity followed by the development of GDM were recognized and treated. Patient compliance was an issue throughout the pregnancy.

At Ms. Wren's first OB visit on May 10, 2016, she was appropriately tested, examined and pertinent medical history was obtained including the history of the birth of her children in 2014 and 2015. Wren's obesity was appropriately noted, and hemoglobin A1C testing revealed that the patient was likely a gestational diabetic. That diagnosis (GDM) was appropriately made and entered into the record on July 18 following additional testing. As Ms. Wren continued with her prenatal care her blood sugar levels were not well controlled. Dr. Hamner was aware that ultrasound examinations suggested that she could be carrying a large infant.

An obstetrician's ability to estimate fetal weight late in pregnancy with an obese mother is limited. Both clinical and ultrasound estimates are subject to a significant margins of error, reported to be as high as  $\pm 15\%$ . Late pregnancy ultrasound estimates of fetal weight are of limited value in clinical decision making for this reason.

As Ms. Wren's pregnancy progressed she was followed appropriately although she failed on several occasions to comply with the requests and instructions of her providers. Glyburide, a diabetic medication, was prescribed on the August 29, 2016 visit. The patient was counseled regarding the ADA diet and management of her gestational diabetes.

In October Ms. Wren was referred to the labor and delivery unit at Baptist-DeSoto on two occasions for fetal surveillance by way of a biophysical profile. The BPP results on October 5 were 8/8 indicating fetal well being. The BPP performed on October 18, was reported as 4/8. Ms. Wren was appropriately retested the following day and her score returned to 8/8, again reassuring as to fetal

status. AFI was normal and cardiac activity was present with a fetal heart rate of 148 bpm. Doppler examination of the umbilical artery was performed and the child was noted to be in a cephalic presentation.

In addition, on October 5 and October 18 ultrasound examinations for gestational age and estimated fetal weight were performed. Dr. Hamner was aware of the results of these studies which suggested that Ms. Wren might be carrying a large (LGA) infant.

Based upon elevations in BP and a 24 hour urine study Dr. Hamner appropriately made the diagnosis of mild preeclampsia on October 12. Random glucose testing continued to reflect elevated sugar levels and fetal surveillance via NST/BPP was recommended and discussed.

On October 25, Dr. Hamner recommended induction of labor at 38 weeks and discussed the need for same and the process of induction with Ms. Wren. This was an appropriate suggestion on Dr. Hamner's part due to Ms. Wren's obesity, evidence which suggested that she might be carrying a large infant and the fact that she had developed gestational diabetes and mild preeclampsia. Ms. Wren gave her informed consent to induction.

On October 30, Ms. Wren was admitted to BMH-DeSoto for induction of labor. Cervical ripening with Cervidil resulted in the onset of labor. Ms. Wren progressed into active labor and progressed well. Fetal heart rate tracings were consistently reassuring. At 1705 Ms. Wren was completely dilated the fetal head of the baby delivered at 1723. At that point shoulder dystocia was recognized. Multiple assistants were available to Dr. Hamner. Dr. Hamner first made an attempt to deliver with gentle traction but this was not successful. Ms. Wren was placed in the McRoberts position and nurses applied supra-pubic pressure. Dr. Hamner then performed a rotational maneuver which is known as the Woods' screw maneuver. Delivery was accomplished. Apgars were 3/7/8.

Care for the child was assumed by the neonatal nurse practitioner. Once the child was in the nursery it was noted that she was not moving her right arm and shoulder, resulting in a diagnosis Erb's Palsy. Dr. Hamner was not advised of the child's condition in this regard.

Dr. Hamner and the hospital employees who assisted him in the delivery complied with standards of care in the management of this obstetrical emergency. There was no excessive or inappropriate traction employed and it is, therefore, more likely than not that this child's brachial plexus injury occurred as a result of the maternal forces of labor.

Dr. Hamner will opine that, with regard to prenatal care, labor management and delivery he complied with the standards of care expected of a reasonable and prudent obstetrician under these circumstances.

Turning to the allegations of negligence contained in the affidavit of Hugh M. Ehrenberg, M.D., Dr. Hamner is expected to opine as follows:

1. Failure to consult with MFM and provide early diabetic teaching.
  - Dr. Hamner is an experienced obstetrician who was trained to manage maternal obesity, gestational diabetes and preeclampsia, all of which are commonly seen in the community based obstetrician's practice. Dr. Hamner regularly manages patients like Ms. Wren in his practice. Referral to a maternal fetal medicine specialist is not required by the standard of care in the treatment of patients such as Ms. Wren. Dr. Hamner provided Ms. Wren with excellent prenatal care which included identification and management of gestational diabetes, obesity and preeclampsia. Diabetic teaching was provided. There is no reason to believe that referral to a maternal fetal medicine specialist would have resulted in an elective cesarean section or avoided the development of shoulder dystocia in this case.
2. Failure to monitor fetal growth after 22 weeks until 34 weeks.
  - Dr. Hamner appropriately monitored fetal growth with physical examinations and timely ultrasound evaluations. As stated above, while the ultrasounds suggested an LGA infant, they are subject to significant margins of error. Dr. Hamner was aware that this infant could be large. He was aware that Ms. Wren had



previously delivered large babies and he was prepared to deal with SD when it developed.

- Shoulder dystocia is most often not predictable or preventable. Most cases of shoulder dystocia occur with infants who are not macrosomic.

3. Lack of medical management with insulin.

- Dr. Hamner recognized the potential for gestational diabetes in this case early on by way of the history of GDM in a prior pregnancy and as a result of Ms. Wren's morbid obesity. The diagnosis was confirmed with laboratory testing and an attempt at management with diet was appropriately undertaken. Ms. Wren was not compliant, glucose levels remained elevated and Glyburide, an oral diabetic medication, was properly ordered. There was no standard of care in the practice which required the use of insulin in this case. Further, it cannot be stated that the use of insulin would have avoided the occurrence of shoulder dystocia.

4. Inadequate monitoring of blood sugar control.

- Dr. Hamner made reasonable and appropriate attempts to educate and counsel this patient regarding her diet and the need for better blood sugar control. As set forth in the medical records and explained in his deposition, Dr. Hamner's efforts were hampered by Ms. Wren's lack of compliance. Nevertheless, Wren's blood sugars were checked regularly, she was provided with information regarding a diabetic diet and she was referred to a professional counselor to discuss the subject. When appropriate she was placed on Glyburide. Dr. Hamner's efforts in this regard were more than adequate to comply with the standard of care.

5. Induction of labor with knowledge of a macrosomic infant prior to induction.

- Dr. Hamner will explain that the basic premise of this allegation is flawed. Estimates of fetal weight via physical examination and/or ultrasound are subject to significant margins of error. Dr. Hamner was aware of the possibility of and suspected that Ms. Wren could be carrying a large baby. However, he could not possibly determine the exact size of this child prior to delivery.
- Induction at 38 weeks was a reasonable step undertaken in view of the patient's gestational diabetes and the development of mild preeclampsia. Elective induction at 38 weeks was appropriate as it provided for delivery at a gestational age when the infant would be able to survive outside the womb without extensive medical intervention. Further, delivery at 38 weeks via induction provided for delivery of a possible LGA infant before the infant continued to grow and gain weight. Potential problems with the progression of Wren's preeclampsia were also avoided. A scheduled Cesarean delivery was not required by the standard of care for this patient. A C-section would certainly have been available had Ms.

Wren developed labor abnormalities, which she did not. Her progress in labor was quite good. Shoulder dystocia could not be predicted in this case.

Dr. Ehrenberg identifies two additional alleged deviations which he states caused no damage to mother or child. These deviations involve inadequate frequency of fetal monitoring and failure to investigate third trimester hypertension. Dr. Hamner disagrees in both instances and will testify that fetal surveillance was properly undertaken in this case and that no fetal anomalies were identified. Preeclampsia was properly identified and treated with blood pressure medication.

Regarding informed consent for induction of labor and route of delivery, induction was a reasonable and appropriate plan of care for Ms. Wren at 38 weeks for the reasons set forth above. Ms. Wren was advised of the risks, benefits and alternatives and she gave her informed consent to proceed with induction. Induction at 38 weeks would provide the option of vaginal delivery with a smaller infant than if pregnancy progressed another week to two weeks and prevented the progression of preeclampsia. Cesarean delivery was not required by the standard of care in this patient. Cesarean delivery was always an option if Ms Wren did not progress adequately in labor. However she progressed quite well. In addition, Cesarean delivery exposes the mother to significant additional risks associated with the surgery.

Dr. Hamner will opine that he and the employees of Southcrest Womens Healthcare complied with all applicable standards of care in the care and treatment of Monica Wren and S.J. D., a minor.

In providing his testimony and discussing his opinions Dr. Hamner may refer to the following medical articles and text excerpts which are identified for use at trial per M.R.E. 803(18).

1. ACOG Practice Bulletin No. 40, Shoulder Dystocia; Nov. 2007: 682-687.
2. A Comparison of Obstetric Maneuvers for the Acute Management of Shoulder Dystocia; Hoffman, et al; Obstet Gynecol, June 2011 : 1-13.

3. Neonatal Brachial Plexus Palsy; ACOG/AAP, 2014.
4. Shoulder Dystocia: The Unpreventable Obstetric Emergency With Empiric Management Guidelines; Gherman, et al; Am J Obstet Gynecol, (2006):657-672.
5. Shoulder Dystocia: Are Historic Risk Factors Reliable Predictors? Ouzounian and Gherman; Am J Obstet Gynecol, (2005):192, 1933-1938.
6. A Comparison of Glyburide and Insulin in Women with GDM; NEJM Vol. 343, No. 16; October 19, 2000.
7. Brachial Plexus Palsy: An In Utero Injury? Gherman, et al; Am J Obstet Gynecol, May 1999: 1303-1307.
8. Severe Brachial Plexus Palsy in Women Without Shoulder Dystocia; Torki, et al; Obstetrics and Gynecology, Vol. 120, No. 3, Sept. 2012:539-541.
9. Controversies Surrounding the Causes of Brachial Plexus Injury; H.F. Sandmire, R. K. Demott, International Journal of Gynecology and Obstetrics, 104 (2009):9-13.
10. Neonatal Brachial Plexus Palsy: What We Know About Causation; Lerner H; www.obmanagement.com, Vol. 26, No. 10, October 2014:43- 52.
11. A Case of Klumpke's Obstetric Brachial Plexus Palsy Following a Cesarean Section; Al-Qottan and El-Sayed, Clin Case Rep, Sept. 2015.
12. Permanent Brachial Plexus Injury Following Vaginal Delivery Without Physician Traction or Shoulder Dystocia; HM Lerner and E Salamon, Am J Obstet Gynecol, March 2008:e7-e8.
13. Isolated Lower Brachial Plexus (Klumpke) Palsy With Compound Arm Presentation: Case Report; EP Buchanan et al, JHS Vol. 3 8A, August 2013: 1567-1570.
14. Neurology of the Newborn, 6<sup>th</sup> Ed, Volpe, et al, Chapter 36, page 1108.
15. ACOG Practice Bulletin No. 175; December, 2016: Ultrasound in Pregnancy.
16. ACOG Practice Bulletin No. 101; February, 2009; Ultrasound in Pregnancy.
17. Diabetes Research and Clinical Practice 76 (2007) 474-475
18. ACOG Practice Bulletin No. 178; May, 2017; Shoulder Dystocia.

19. Erb's Palsy Without Shoulder Dystocia, Sandmire, Int'l J of GYN & OB (2002) 253-256.
20. Brachial Plexus Palsy Associated with Cesarean Section: An In Utero Injury; Gherman, Am J Ob-Gyn 177, No. 5, 1997.
21. Induction of Labor, ACOG Practice Bulletin No. 107; August, 2009.
22. Management of Intrapartum Fetal Heart Rate Tracings, ACOG Practice Bulletin No. 116; November 2010.
23. Glyburide for the Management of Gestational Diabetes; AJOG (2006) 195, 1090-4.

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**Jackson, MS 39216**

Dr. Parker is tendered as an expert in the field of Pediatrics and Pediatric Neurology. She will provide testimony regarding Sariah Deberry's treatment at the Methodist LeBonheur Children's Hospital; her current condition as reflected in the medical records, photographs, videos and parents' depositions; and her long-term prognosis.

Dr. Parker's CV is attached hereto as Exhibit 2 and incorporated herein by reference. Dr. Parker is familiar with shoulder dystocia and brachial plexus injuries (Erb's Palsy/Klumpke's Palsy). Dr. Parker routinely treats patients diagnosed with a brachial plexus injury. She is familiar with the neurological development of children such as Sariah who have been diagnosed with a brachial plexus injury. Dr. Parker charges \$650.00 per hour for her work as a consultant in medical-legal matters.

Dr. Parker understands that her opinions, in order to be admissible, must be stated with reasonable medical certainty, and not as mere possibilities.

Dr. Parker's opinions in this case are based upon her education, training and experience as a Pediatric Neurologist. Dr. Parker has reviewed Sariah's medical records from Baptist-DeSoto, Methodist LeBonheur Children's Hospital, DeSoto Children's Clinic, Tate County Health Department, the child's therapy records, Dr. Katz's IME and Bruce Brawner's Life Care Plan. Parker has reviewed the depositions of Monica Wren and Benson Deberry. She may refer to the content of the depositions and the videos/photos produced in stating her opinions in this case.

Dr. Parker will review and may refer to any medical records made available after the filing of this pleading. She will review and may refer to any depositions taken in this case after the filing

of this pleading.

Dr. Parker will explain the content of the medical records including the medical terminology contained therein. She may comment or opine as to any information contained within Sariyah Deberry's medical records from Baptist DeSoto or Methodist LeBonheur Children's Hospital. Dr. Parker will use anatomical drawings to illustrate the brachial plexus, the various nerves and nerve roots to explain how stretching of the brachial plexus can cause injury to the nerve roots.

Dr. Parker has significant experience in the assessment, care and treatment of patients presenting with brachial plexus injuries. She routinely treats patients who have been diagnosed with brachial plexus injuries.

Based upon her experience, education and training, and further based upon the information contained in the medical records, depositions, photographs and videos, Dr. Parker is expected to offer the following opinions at trial:

1. Dr. Parker will opine that Sariyah Deberry suffered an injury to her C5-C6 and C8-T1 nerve roots. The extent of function which is present in the C6 nerve root distribution and the description of the injury lead Dr. Parker to conclude that Sariyah Deberry suffered a stretching of the C6 nerve root.

2. Dr. Parker will opine that Sariyah Deberry presented to Dr. Elena Caron (LeBonheur) in November, 2019, when she was 3 years of age. At the time she was first seen by Dr. Caron, Dr. Caron documented Erb's/Klumpke Palsy. Dr. Caron noted weakness with inability to supinate at the forearm with weak extension and flexion of the wrist, weak grasp and weak external rotation. The child demonstrated mild atrophy of the right arm above and below the elbow. Dr. Caron's diagnosis was brachial plexus injury, diffuse with incomplete recovery. Dr. Caron recommended six (6) month follow-ups with Occupational Therapy and shoulder ROM and stretch exercises at

home.

3. Dr. Parker will opine that when the child followed up with LeBonheur Orthopedics in May, 2020, she was doing very well. Sariah's flexion and abduction had improved and she was documented to be using her right hand fairly well.

4. Dr. Parker will opine that the videos that she has reviewed, along with a description of Sariah by her parents, indicate that Sariah has good function in her injured arm. Sariah's parents and medical care providers describe difficulty with shoulder abduction. This limitation is related to the C6 injury.

5. Dr. Parker will opine that Sariah's primary limitation will be the inability to raise her arm above her head. Sariah appears to be able to raise her arm to the level of her shoulder, and slightly higher. This functional limitation would be expected with an injury of the C6 nerve root.

6. Dr. Parker will opine that Sariah's grip strength in the affected hand appears to be good to normal and will not affect her functionality.

7. Dr. Parker will opine that lack of physical therapy/occupational therapy and/or exercise therapy pose a risk to Sariah developing a "frozen shoulder". She will opine that the more Sariah uses her shoulder, the better off she will be.

8. Dr. Parker has reviewed Dr. Katz's IME and projected future care. Dr. Parker will opine as follows:

a. **Occupational Therapy** – The child needs to have at least a monthly visit with an Occupational Therapist. The visit can be provided through the Tate County School System wherein the therapist would develop a home plan for the child;

b. **Anticipated Physical Medicine Care** – Dr. Parker does not believe Sariah needs



to be seen one time per year by a Physiatrist. Sariyah is currently being followed by Dr. Elena Caron, a Pediatric Neurologist;

c. **Medications** – Dr. Parker will opine that the medical records do not indicate Sariyah is currently experiencing myofascial pain. Should Sariyah develop myofascial pain in the future, it can be treated with over-the-counter Tylenol, Advil or Aleve. Dr. Parker will opine that Dr. Katz's recommendation for Savella is misplaced. Savella is one of the most expensive medications available to treat myofascial pain. Dr. Parker noted that Bruce Brawner did not include a generic substitute for Savella in his Life Care Plan. Dr. Parker will opine that a generic substitute is available and would treat any myofascial pain Sariyah may develop in the future

d. **Psychological Intervention** – Dr. Parker does not believe the child will require psychologic counseling as a result of her injury;

e. **Diagnostic Studies** – Dr. Parker does not recommend "prophylactic" diagnostic studies submitting the child to radiation. The child has less than a 50% chance of developing scoliosis and diagnostic studies should only be ordered when indicated;

f. **EMG** – Dr. Parker does not recommend an EMG or nerve conduction study. Dr. Caron has not ordered an EMG/NCS. The EMG/NCS at this point would not offer any useful additional information;

g. **Durable Medical Equipment** – Dr. Parker agrees with Dr. Katz that the child does not require any durable medical equipment. Dr. Parker will opine that the items addressed by Bruce Brawner are specialty items and not required for Sariyah Deberry;

h. **Recreational Therapy** – Dr. Parker does not recommend Recreational Therapy; and

i. **Specialty Therapeutic Recommendations** – Dr. Parker recommends that the child play an instrument to aid in functionality. Dr. Parker recommends obtaining this service through

band at her school.

9. Dr. Parker will opine that it is well known that endogenous/maternal forces of labor can cause brachial plexus injuries. She will opine that brachial plexus injuries have been documented to occur in cases where there was no shoulder dystocia and in cases where children were delivered via cesarean section. She will opine that endogenous/maternal forces of labor are felt to be generally stronger than the exogenous forces applied by the obstetrician.

Dr. Parker may refer to the following medical treatise in providing her testimony in this case.

The treatise is identified for use in direct examination per M.R.E. 803(18).

1. Neurology of the Newborn, 6<sup>th</sup> Ed., Volpe, et al, Chapter 36, p. 1108.
2. Erb's Palsy Without Shoulder Dystocia, International Journal of Gynecology and Obstetrics 78 (2002) 253-256.

**JAMES MARTIN TUCKER, M.D.  
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Dr. Tucker currently serves as Chairman of the Department of Obstetrics and Gynecology at the University of Mississippi Medical Center in Jackson. In addition to his OB-GYN training Dr. Tucker is trained and certified in the subspecialty of maternal-fetal medicine. For approximately 29 years prior to his appointment at UMMC, Dr. Tucker was engaged in the private practice of obstetrics and maternal-fetal medicine at Jackson Healthcare for Women in Flowood, MS. Dr. Tucker's curriculum vitae is attached as Exhibit 3 and incorporated herein by reference.

By virtue of his medical education, training and experience, Dr. Tucker is familiar with the standards of care which prevailed in the practice of obstetrics in 2016 with regard to patients presenting as did Monica Wren. He has experience in the treatment of pregnant patients presenting with diabetes, gestational diabetes and preeclampsia. He has experience in dealing with the obstetrical emergency known as shoulder dystocia. He has experience in the use of ultrasound in pregnancy. Dr. Tucker is, therefore, qualified to provide opinion testimony as an expert in the fields of obstetrics and maternal-fetal medicine with regard to the issues presented in this case.

In addition to his personal experience in the practice of obstetrics and maternal-fetal medicine, Dr. Tucker has reviewed and will rely upon the following medical records and related documents in offering his testimony and opinions in this case:

Medical Records:

- Southcrest Womens Healthcare - Monica Wren;
- Baptist Memorial Hospital DeSoto - Monica Wren;

- Baptist Memorial Hospital DeSoto - S.J.D., a minor;
- Senatobia Childrens' Clinic - S.J.D., a minor;
- Pathology Group of the Mid-South, P.C. - Monica Wren;
- Panola Medical Center - S.J.D., a minor;
- MLH Clinics: Neurology/Cardiology/Orthopaedics - S.J.D., a minor;
- CTS, LLC - S.J.D., a minor; and
- Rehab Technology/Tate County Health Department - S.J.D., a minor.

Depositions:

- Dabney Hamner, M.D.;
- Monica Wren; and
- Joyce Wren.

Miscellaneous:

- Pleadings identifying the plaintiffs' experts including Dr. Hugh M. Ehrenberg.

Dr. Tucker will also review and testify regarding medical records, medical literature and/or depositions produced after the date of this pleading.

The facts which form the bases of Dr. Tucker's opinions are contained in the medical records and depositions mentioned above. Those records and depositions are incorporated herein by reference. Dr. Tucker reserves the right to comment on any and all of the data contained in the records and depositions.

Based upon his medical education, training and experience Dr. Tucker will opine that the care provided to Monica Wren and S.J.D., a minor at Southcrest Womens Healthcare and at BMH-DeSoto by clinic employees and, specifically, by Dr. Dabney Hamner was reasonable, appropriate and was provided in accordance with standards of care in the practice of obstetrics.

Dr. Tucker will respond to and refute the allegations attributed to Dr. Hugh M. Ehrenberg who alleges that Dr. Hamner and Southcrest Womens Healthcare were guilty of negligence in regards to the services provided to Ms. Wren and S.J.D., a minor.

Dr. Tucker will explain that shoulder dystocia is often defined as a delivery that requires additional obstetric maneuvers following failure of gentle downward traction on the fetal head to affect delivery of the shoulders. Retraction of the delivered fetal head against the maternal perineum (turtle sign) maybe present and may assist in the diagnosis. Shoulder dystocia is caused by the impaction of the anterior fetal shoulder behind the maternal pubis symphysis. Shoulder dystocia is most often an unpredictable and unpreventable obstetrical emergency. Failure of the shoulders to deliver spontaneously places both the mother and child at risk for serious injury.

Various risk factors have been described in association with neonatal brachial plexus palsy. (NBPP). They include fetal malposition, labor induction, labor abnormalities, operative vaginal delivery, fetal macrosomia and prior shoulder dystocia. However, except for instances of prior shoulder dystocia, these risk factors have not been shown to be statistically significant or clinically useful predictors of the occurrence of SD or NBPP. Most NBPP cases (greater than 80%) occur in women without known risk factors. Risk factors for shoulder dystocia are not reliable predictors for its occurrence.

Once shoulder dystocia develops, the primary objective is to deliver the fetus before he/she suffers a hypoxic ischemic brain injury. A series of obstetrical maneuvers have been developed over the years for use in response to shoulder dystocia. The maneuvers employed in this case (McRoberts maneuver/supra-pubic pressure/rotation of the anterior shoulder-Woods screw maneuver) are recognized, approved and widely used obstetrical maneuvers when confronted with shoulder dystocia.

NBPP, to include an Erb's palsy such as is described in S.J.D.'s medical records, can occur in multiple ways. Maternal forces of labor alone are a known cause of NBPP. Further, properly

applied obstetrical maneuvers can result in NBPP. There is no high quality or consistent data available to suggest that NBPP is caused only by the application of excessive exogenous force (physician applied) and/or excessive force applied in an inappropriate direction. The existence of a brachial plexus injury following shoulder dystocia does not suggest that inappropriate exogenous force caused the injury.

Medical records in this case reveal that Dr. Hamner and his associates at Southcrest Womens Healthcare provided reasonable and appropriate prenatal care for Monica Wren. Risk factors for macrosomia including morbid obesity followed by the development of GDM were recognized and treated. Patient compliance was an issue throughout the pregnancy.

At Ms. Wren's first OB visit on May 10, 2016, she was appropriately tested, examined and pertinent medical history was obtained including the history of the birth of her children in 2014 and 2015. Wren's obesity was appropriately noted, and hemoglobin A1C testing revealed that the patient was likely a gestational diabetic. That diagnosis (GDM) was appropriately made and entered into the record on July 18, following additional blood sugar testing. As Ms. Wren continued with her prenatal care her blood sugar levels were not well controlled. Ultrasound examinations suggested that she could be carrying a large infant.

Dr. Tucker will explain that an obstetrician's ability to estimate fetal weight late in pregnancy with an obese mother is limited. Both clinical and ultrasound estimates are subject to a significant margins of error, reported to be as high as  $\pm 15$  to 20%. Late pregnancy ultrasound estimates of fetal weight are of limited value in clinical decision making for this reason.

As Ms. Wren's pregnancy progressed she was monitored appropriately although she failed on several occasions to comply with the requests and instructions of her providers. Glyburide, a

diabetic medication, was prescribed on the August 29, 2016 visit. The patient was counseled regarding the ADA diet and management of her gestational diabetes.

In October Ms. Wren was referred to the labor and delivery unit at Baptist-DeSoto on two occasions for fetal surveillance by way of a biophysical profile. The BPP results on October 5 were 8/8 indicating fetal well being. The BPP performed on October 18, was reported as 4/8. Ms. Wren was appropriately tested the following day and her score returned to 8/8, again reassuring as to fetal status. AFI was normal and cardiac activity was present with a fetal heart rate of 148 bpm. Doppler examination of the umbilical artery was performed and it was noted that the child was in a cephalic presentation.

In addition, on October 5 and October 18 ultrasound examinations for gestational age and estimated fetal weight were performed. Dr. Hamner was aware of the results of these studies which suggested that Ms. Wren might be carrying a large (LGA) infant.

Based upon elevations in BP and a 24 hour urine study Dr. Hamner appropriately made the diagnosis of mild preeclampsia on October 12. Random glucose testing continued to reflect elevated sugar levels and fetal surveillance via NST/BPP was recommended and discussed.

On October 25, Dr. Hamner recommended induction of labor at 38 weeks and discussed the need for same and the process of induction with Ms. Wren. This was an appropriate suggestion on Dr. Hamner's part due to Ms. Wren's obesity, evidence which suggested that she might be carrying a large infant and the fact that she had developed gestational diabetes and mild preeclampsia. Ms. Wren gave her informed consent to induction on October 25.

On October 30, Ms. Wren was admitted to BMH-DeSoto for induction of labor. Cervical ripening with Cervidil resulted in the onset of labor. Ms. Wren progressed into active labor. Fetal



heart rate tracings were consistently reassuring. At 1705 Ms. Wren was completely dilated and nurses' notes indicate that the fetal head baby delivered at 1723. At that point shoulder dystocia was recognized. Multiple assistants were available to Dr. Hamner. An attempt with gentle traction to deliver was not successful. Ms. Wren was placed in the McRoberts position and nurses applied supra pubic pressure. Dr. Hamner then performed a rotational maneuver which is referenced in medical literature as the Woods' screw maneuver. Delivery was accomplished. Apgars were 3/7/8. Care for the child was provided by a neonatal nurse practitioner. Once the child was in the nursery it was noted that she was not moving her right arm and shoulder, resulting in a diagnosis Erb's Palsy.

Dr. Hamner and the hospital employees who assisted him in the delivery complied with standards of care in the management of this obstetrical emergency. There is no evidence available to Dr. Tucker which would suggest the use of excessive or inappropriate traction and it is, therefore, more likely than not that this child's brachial plexus injury occurred as a result of maternal forces of labor.

Dr. Tucker will opine that, with regard to prenatal care, labor management and delivery Dr. Hamner complied with the standards of care expected of a reasonable and prudent obstetrician under these circumstances. Turning to the allegations of negligence contained in the affidavit of Hugh M. Ehrenberg, M.D., Dr. Tucker is expected to opine as follows:

1. Failure to consult with MFM and provide early diabetic teaching.
  - Dr. Hamner is an experienced obstetrician who was trained to manage maternal obesity, gestational diabetes and preeclampsia, all of which are commonly seen in the community based obstetrician's practice. Referral to a maternal fetal medicine specialist (such as Dr. Tucker) is not required by the standard of care in the treatment of patients such as Ms. Wren. Dr. Hamner provided Ms. Wren with excellent prenatal care which included identification and management of gestational diabetes, obesity and preeclampsia. Diabetic teaching was provided.

There is no reason to believe that referral to a maternal fetal medicine specialist would have resulted in an elective cesarean section or avoided the development of shoulder dystocia in this case.

2. Failure to monitor fetal growth after 22 weeks until 34 weeks.

- Dr. Hamner appropriately monitored fetal growth with physical examinations and timely ultrasound evaluations. As stated above, while the ultrasounds suggested an LGA infant, they are subject to significant margins of error. Medical records clearly indicate that Dr. Hamner was aware that this infant could be large. He was aware that Ms. Wren had previously delivered large babies and he was prepared to deal with SD when it developed.
- Shoulder dystocia is most often not predictable or preventable. Most cases of shoulder dystocia occur with infants who are not macrosomic.

3. Lack of medical management with insulin.

- Dr. Hamner recognized the potential for gestational diabetes in this case early on by way of the history of GDM in a prior pregnancy and as a result of Ms. Wren's morbid obesity. The diagnosis was confirmed with laboratory testing and an attempt at management with diet was appropriately undertaken. Ms. Wren was not compliant, glucose levels remained elevated and Glyburide, an oral diabetic medication, was properly ordered. There was no standard of care in the practice which required the use of insulin in this case. Further, it cannot be stated that the use of insulin would have avoided the occurrence of shoulder dystocia.

4. Inadequate monitoring of blood sugar control.

- Dr. Hamner made reasonable and appropriate attempts to educate and counsel this patient regarding her diet and the need for better blood sugar control. As set forth in the medical records and explained in his deposition, Dr. Hamner's efforts were hampered by Ms. Wren's lack of compliance. Nevertheless, Wren's blood sugars were checked regularly, she was provided with information regarding a diabetic diet and she was referred to a professional counselor to discuss the subject. When appropriate she was placed on Glyburide. Dr. Hamner's efforts in this regard were more than adequate to comply with the standard of care.

5. Induction of labor with knowledge of a macrosomic infant prior to induction.

- Dr. Tucker will explain that the basic premise of this allegation is flawed. Estimates of fetal weight via physical examination and/or ultrasound are subject to significant margins of error. While Dr. Hamner clearly stated in his medical records that he was aware of the possibility of and suspected that Ms. Wren could

be carrying a large baby, he could not possibly determine the exact size of this child prior to delivery. Induction at 38 weeks was a reasonable step undertaken in view of the patient's gestational diabetes and the development of mild preeclampsia. Elective induction at 38 weeks was appropriate under these circumstances as it provided for delivery at a gestational age when the infant would be able to survive outside the womb without extensive medical intervention. Further, intervention and delivery at 38 weeks via induction provided for delivery of a possible LGA before the infant continued to grow and gain weight. Potential problems with the progression of Wren's preeclampsia were also avoided. A scheduled Cesarean delivery was not required by the standard of care for this patient. A C-section would certainly have been available had Ms. Wren developed labor abnormalities, which she did not. Her progress in labor was quite good. Shoulder dystocia could not be predicted in this case.

Dr. Ehrenberg identifies two additional alleged deviations which he states caused no damage to mother or child. These deviations involve inadequate frequency of fetal monitoring and failure to investigate third trimester hypertension. Dr. Tucker disagrees in both instances and will testify that fetal surveillance was properly undertaken in this case and that no fetal anomalies were identified. Preeclampsia was properly identified and treated with blood pressure medication.

Dr. Tucker will take issue with Dr. Ehrenberg's statement regarding a lack of informed consent for induction of labor and route of delivery. Induction was a reasonable and appropriate plan of care for Ms. Wren at 38 weeks for the reasons set forth above. Induction at 38 weeks would provide the option of vaginal delivery with a smaller infant than if pregnancy progressed another week to two weeks and prevent the progression of preeclampsia. Cesarean delivery was not required by the standard of care in this patient. Cesarean delivery was always an option if Ms Wren did not progress adequately in labor. However she progressed quite well. In addition, Cesarean delivery exposes the mother to significant additional risks associated with the surgery.

In summary, Dr. Tucker will testify that Dr. Hamner and the employees of Southcrest Womens Healthcare complied with all applicable standards of care in the care and treatment of

Monica Wren and S.J. D., a minor.

In providing his testimony and discussing his opinions Dr. Tucker may refer to the following medical articles and text excerpts which are identified for use at trial per M.R.E. 803(18).

1. ACOG Practice Bulletin No. 40, Shoulder Dystocia; Nov. 2007: 682-687.
2. A Comparison of Obstetric Maneuvers for the Acute Management of Shoulder Dystocia; Hoffman, et al; Obstet Gynecol, June 2011 : 1-13.
3. Neonatal Brachial Plexus Palsy; ACOG/AAP, 2014.
4. Shoulder Dystocia: The Unpreventable Obstetric Emergency With Empiric Management Guidelines; Gherman, et al; Am J Obstet Gynecol, (2006):657-672.
5. Shoulder Dystocia: Are Historic Risk Factors Reliable Predictors? Ouzounian and Gherman; Am J Obstet Gynecol, (2005):192, 1933-1938.
6. A Comparison of Glyburide and Insulin in Women with GDM; NEJM Vol. 343, No. 16; October 19, 2000.
7. Brachial Plexus Palsy: An In Utero Injury? Gherman, et al; Am J Obstet Gynecol, May 1999: 1303-1307.
8. Severe Brachial Plexus Palsy in Women Without Shoulder Dystocia; Torki, et al; Obstetrics and Gynecology, Vol. 120, No. 3, Sept. 2012:539-541.
9. Controversies Surrounding the Causes of Brachial Plexus Injury; H.F. Sandmire, R. K. Demott, International Journal of Gynecology and Obstetrics, 104 (2009):9-13.
10. Neonatal Brachial Plexus Palsy: What We Know About Causation; Lerner H; www.obmanagement.com, Vol. 26, No. 10, October 2014:43- 52.
11. A Case of Klumpke's Obstetric Brachial Plexus Palsy Following a Cesarean Section; Al-Qottan and El-Sayed, Clin Case Rep, Sept. 2015.
12. Permanent Brachial Plexus Injury Following Vaginal Delivery Without Physician Traction or Shoulder Dystocia; HM Lerner and E Salamon, Am J Obstet Gynecol, March 2008:e7-e8.
13. Isolated Lower Brachial Plexus (Klumpke) Palsy With Compound Arm Presentation: Case Report; EP Buchanan et al, JHS Vol. 3 8A, August 2013: 1567-1570.

14. Neurology of the Newborn, 6<sup>th</sup> Ed, Volpe, et al, Chapter 36, page 1108.
15. ACOG Practice Bulletin No. 175; December, 2016: Ultrasound in Pregnancy.
16. ACOG Practice Bulletin No. 101; February, 2009; Ultrasound in Pregnancy.
17. Diabetes Research and Clinical Practice 76 (2007) 474-475
18. ACOG Practice Bulletin No. 178; May, 2017; Shoulder Dystocia.
19. Erb's Palsy Without Shoulder Dystocia, Sandmire, Int'l J of GYN & OB (2002) 253-256.
20. Brachial Plexus Palsy Associated with Cesarean Section: An In Utero Injury; Gherman, Am J Ob-Gyn 177, No. 5, 1997.
21. Induction of Labor, ACOG Practice Bulletin No. 107; August, 2009.
22. Management of Intrapartum Fetal Heart Rate Tracings, ACOG Practice Bulletin No. 116; November 2010.
23. Glyburide for the Management of Gestational Diabetes; AJOG (2006) 195, 1090-4.

**RUSTIN T. YERKES, Ph.D.  
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Dr. Yerkes, Associate Professor of Finance at Samford University's Brock School of Business in Birmingham will opine regarding the economic analysis provided by Dr. Bill Mr. Brister and, specifically, with regard to the issues of lost earnings, lost HHS and life care plan costs.

Dr. Yerkes' report dated September 17, 2021 is attached as Exhibit 4.