IN THE CIRCUIT COURT OF DESOTO COUNTY, MISSISSIPPI

MONICA WREN, as Guardian,
Mother and Next Friend of SJD, a minor — PLAINTIFF

vs.

CAUSE NO: CI2020-399GCD

DABNEY HAMNER, M.D.; METHODIST LEBONHEUR HEALTHCARE d/b/a SOUTHCREST WOMEN'S HEALTHCARE; and JOHN DOES 1-5 — DEFENDANTS

PRE-TRIAL ORDER

The above case appearing to be ready for trial, the parties submit the following pre-trial order:

1. Counsel with full authority to speak for the parties in this cause have entered into this pre-trial order. The parties are bound by the representations contained in this pre-trial statement.

2. In this pre-trial statement, counsel represent to the Court:

   a. They have or intend to stipulate all relevant and material facts not genuinely at issue.

   b. All information contained herein was prepared by counsel after preparation with the same thoroughness as for trial to conserve the time of counsel and the Court.

3. The following claims (including claims stated in the complaint and counter claims, if any) have been filed:

   A. **PLAINTIFF:**

   Plaintiff has filed claims against Dabney Hamner, M.D. and Methodist LeBonheur Healthcare d/b/a Southcrest Women's Healthcare for negligence for failure to monitor fetal growth after 22 weeks; failure to obtain timely or any referral of Monica Wren and SJD to high risk maternal fetal medicine specialists and endocrinologist; failure to adequately manage pregestational diabetes; failure to monitor blood sugar control; induction of labor without proper estimate of fetal size; failure to adequately monitor labor delivery and inadequate frequency of fetal monitoring; failure to protect fetus from harm during vaginal delivery; failure to consider and inform Monica Wren of safest delivery options; failure to considers risks of preeclampsia when selecting induction of labor; failure to recognize, diagnose and treat likely complications of labor under the circumstances of the pregnancy; failure to consult with or offer and pursue C-Section for the delivery of

SJD; failure to adequately recognize and prevent Erb's palsy; failure to use proper techniques and procedures to deliver SJD.

B. **DEFENDANTS:**

The Defendants contend that Dr. Dabney Hamner complied with the applicable standards of care in connection with the obstetrical services he provided to Monica Wren and SJD in all respects and at all times at which medical services were provided. The Defendants further contend that SJD's injuries did not occur as a result of any breach of the standard of care by either defendant.

4. There is the following jurisdictional and/or venue question: **None**

5. There are pending motions as follows:

A. **PLAINTIFF:**

Plaintiff's Motion to Exclude or Limit Testimony of Colette C. Parker, M.D. [Dkt. 126];

Plaintiff's Motion in Limine to Exclude Testimony by Dabney Hamner, M.D. and James Martin Tucker, M.D. as to Specific Standards of Care Applicable to Monica Wren [Dkt. 134]; and

Plaintiff's Motion for Enlargement of Jury Venire [Dkt. 135].

B. **DEFENDANTS:**

Motion to Exclude Reports of Bruce Brawner and Howard Katz, M.D. [Dkt. 129];

Dr. Hamner's First Motion *in Limine* [Dkt. 130]; and

Dr. Hamner's Second Motion *in Limine* [Dkt. 133].

6. The following is a concise summary of the ultimate facts as claimed by:

A. **PLAINTIFF:**

Dr. Hamner delivered SJD on or about October 31, 2016. Because of the negligent acts and omissions of Hamner and other medical personnel assisting in the labor and delivery, SJD suffered permanent brachial plexus and other injuries. The acts and omissions of Hamner and other medical employees assisting in the delivery of SJD constitute actionable negligence as they were proximate contributing causes of the injuries and damages to SJD who now suffers from Erb's palsy, a permanent and irreversible paralysis of her right arm. Defendants, both individually and collectively, provided inadequate healthcare and treatment that departed from accepted standards of medical care and healthcare safety, which proximately resulted in the injuries and damages suffered by plaintiffs.

Monica Wren was a 30-year-old gravida 3 para 2 who had a due date of 11/14/2016 with two recent vaginal deliveries. Prior obstetrical history was unremarkable but for obesity and multiparous. However, the prenatal care for SJD was complicated by obesity, gestational diabetes, large for gestational age baby, and mild preeclampsia and negligent prenatal care by Hamner, medical employees, nurses and other employees of MLH, and BMH, its nurses and other medical employees.

Monica Wren began receiving prenatal care at 13 weeks gestation weighing 345 pounds, with a corresponding BMI of 67.4. This is a Class III obesity, which is one fact that warranted classifying her pregnancy as high-risk.

She was screened for pre-existing diabetes with a result of her hemoglobin Alc being 6.1, indicative of type 2 diabetes. There was no diabetic screening, care or management for obesity, counseling with regard to diet, exercise, glucose monitoring, or counseling with regard to the implications of her various pregravid conditions on the outcomes of pregnancy according to the standard of care applicable to Hamner.

1. No referral was made to a subspecialist in maternal-fetal medicine ("MFM"), endocrinology, or diabetes care. Each of these tasks were required by the standard of care of a reasonable, prudent, minimally competent obstetrician. The standard of care here includes referral for consultative care with any of the following: MFM, Endocrinology, diabetes education, and/or a dietician. There was no such referral made, which violated the standard of care.

Alternatively, he never satisfied or even pursued the additional monitoring and testing that would have been pursued by a maternal-fetal medicine physician. There was similarly no management with regard to obesity or diabetes. No referral was made for MFM, diabetic teaching, or dietitian services during the first or early second trimester of pregnancy. Each of these tasks were required by the standard of care of a reasonable, prudent, minimally competent obstetrician.

2. There was no discussion with Wren with regard to the risks of diabetes in pregnancy, including, but not limited to, large for gestational age infants and delivery complications. Wren was not sent for consultation with MFM nor was she scheduled for an appropriate, third trimester ultrasound assessment of interval fetal growth. Each of these tasks were required by the standard of care of a reasonable, prudent, minimally competent obstetrician.

3. Her limited glucose test results were reviewed, with a result of 209 mg/dl, indicative of type 2 diabetes, and a note for nurse to call with instructions. No nurse called Wren regarding her diabetic screening result, care and management for obesity, counseling with regard to diet, exercise, glucose monitoring, or counseling with regard to the implications of her various pregravid conditions on the outcomes of pregnancy. No referral was made to subspecialist in MFM, endocrinology, or diabetes care. All of these tasks were required by the applicable standard of care as a reasonable, prudent, minimally competent obstetrician. The standard of care here includes referral for consultative care with any of the following: MFM, Endocrinology, and diabetes education. There was no such referral made, which further violates this standard of care.

4. Ms. Wren was prescribed a low-dose of glyburide for blood sugar control at a 28-week and 6-day gestational age visit. Her random fingerstick blood sugar at this visit was 232. Of note, her blood pressure at this visit is 143/87 with proteinuria, but there was no workup for severe preeclampsia. Still there was no referral to MFM for consultation in this high-risk pregnancy. There was no discussion with Wren with regard to the risks of poorly managed probable pre-gestational diabetes, or for that matter her hypertensive disease in pregnancy. There was no referral made for MFM, or for sonographic evaluation of fetal growth. There was no fetal testing performed or planned. All of these tasks were required by the applicable standard of care for a reasonable, prudent, minimally competent obstetrician. The standard of care here includes referral for consultative care with any of the following: MFM, Endocrinology and diabetes education. There was no such referral made, which violates this standard or care. Again, if there was no referral then Dr. Hamner himself was required to render the additional care according to the standard of care.

Wren did not have her first fetal nonstress test at 34 weeks gestational age. She did not undergo further fetal non-stress testing or Biophysical Profile ("BPP") until 35 weeks despite three conditions associated with third trimester Intra Uterine Fetal Demise (IUFD): obesity, poorly controlled diabetes and hypertensive disease in pregnancy. There was no referral made for MFM, or for sonographic evaluation of fetal growth, according to the standard of care for a reasonable, prudent, minimally competent obstetrician. Each of these tasks were required by the standard of care of a reasonable, prudent, minimally competent obstetrician. There was no fetal testing performed or planned. Again, this is a blatant departure from the standard of care that dictates twice weekly fetal assessment to include non-stress testing to begin at 33 weeks. With barriers to compliance, the standard of care requires surveillance at 32 weeks, with frequent assessment of fetal growth as well. This lack of testing exposes the fetus to the risk of death and is a breach of the standard of care. All of these tasks were required by the applicable standard of care as a reasonable, prudent, minimally competent obstetrician. The standard of care here includes referral for consultative care with any of the following: MFM, Endocrinology and diabetes education. There was no such referral made, which violates this standard of care.

5. Prenatal visits were done at 35- and 37-weeks gestational age. At the 37-week visit the patient was introduced to the concept of induction of labor. Her blood pressure at this visit is 145/99. She has 2+ protein at this visit. No blood work was sent at any point in pregnancy for the evaluation of severe preeclampsia as required by the standard of care. All of these tasks were required by the applicable standard of care as a reasonable, prudent, minimally competent obstetrician.

6. Wren was admitted to BMH at 36 weeks gestational age, for gestational diabetes with poor control and third trimester antepartum mild preeclampsia. During her admission to BMH Wren signed a consent for Hamner to perform: treatment, delivery, possible c-section. During Wren's treatment at BMH a fetal ultrasound which found an estimated fetal weight of 8 lbs. 8 oz. (3851 g). Wren's discharge diagnosis were: antepartum mild preeclampsia, third trimester; gestational diabetes melilotus in third trimester; high risk pregnancy in third

trimester; macrosomia; and obesity during pregnancy in third trimester. No referral was made to subspecialist in MFM, endocrinology, or diabetes care, required by the applicable standard of care as a reasonable, prudent, minimally competent obstetrician. The standard of care here includes referral for consultative care with any of the following: MFM, Endocrinology, and diabetes education. There was no such referral made, which further violates this standard of care.

7. The indication for delivery prior to 39 weeks was not documented, representing another deviation from the standard of care of a reasonable, prudent, minimally competent obstetrician.

8. There was no discussion with Wren with regard to expected fetal weight, delivery complications, or options for route of delivery. Induction under these circumstances results in the delivery of a massively overgrown child, which is deviation from the standard of care of a reasonable, prudent, minimally competent obstetrician, particularly when all involved were aware of the information and planning derived from her 36-week inpatient stay referenced in above.

9. An ultrasound done in the third trimester at BMH and at 35 weeks indicated large for gestational age. Ms. Wren should have had an ultrasound estimation of fetal weight proximate-to-delivery (< 12 hours), according to the standard of care. She was at great risk for fetal overgrowth, and this risk was not managed, mitigated or anticipated, as required by the standard of care of a reasonable, prudent, minimally competent obstetrician. With such an ultrasound, fetal weight estimates over 4200-4500 grams in a diabetic are indications for unlabored cesarean delivery to avoid risk of shoulder dystocia and permanent injury to the offspring, according to the standard of care of a reasonable, prudent, minimally competent obstetrician. None of this was done, and the patient was allowed to deliver vaginally. Again, this is a blatant disregard for the standard of care of a reasonable, prudent, minimally competent obstetrician or patient safety it is supposed to protect.

10. SJD's birth weight was 10 pounds 15 ounces (4970 g). A shoulder dystocia was apparently encountered at the time of delivery. Documentation of maneuvers performed include McRoberts, suprapubic pressure, and wood's screw. While documentation is not precise, the time between delivery of the head and shoulder appears to be 2 minutes. *Apgars* were 3 and 7.

11. There were several opportunities to intervene on behalf of the wellbeing of SJD, and pertinent deviations from the standard of obstetric care. These deviations would be recognized by any competently trained reasonably prudent minimally competent obstetrician. Defendants' deviations from these standards of care, placed SJD at risk of labor complications, all of which could have been avoided by delivery of appropriate medical care which the lack thereof, proximately caused Erb's palsy and irreversible permanent neurological and other injuries to SJD.

12. Multiple, prejudicial delays in treatment, care and diagnosis occurred as a result of the negligent care of the named Defendants. The delay and negligence in care proximately caused the Erb's palsy, neurological and other injuries suffered by SJD. Specifically and primarily, SJD was injured due to Monica Wren being induced into labor for vaginal birth. This should never have been advocated or

allowed without strong counseling against it. Rather, the shoulder injury would have been avoided by a C-section delivery.

B. **DEFENDANTS:**

On May 10, 2016, Monica Wren presented to Southcrest Women's Healthcare as a new obstetrical patient. Ms. Wren was 30 years old and had previously delivered two children. She was 5'7" tall and weighed 345 pounds with a BMI of 67. Laboratory studies were ordered which included a hemoglobin A1C test, urinalysis and pregnancy test which was positive. Ultrasound examination for dating was consistent and an EDC was entered as November 12, 2016, based on ultrasound.

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

Ms. Wren was given an appointment to follow-up in three weeks. In the meantime, she was called on May 16, to report that her lab test revealed anemia and a prescription for iron was provided. The elevated hemoglobin A1C 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. Ms. Wren did not return to Southcrest for her second OB visit until June 13. She had no complaints on presentation. Her weight had increased to 348 pounds. A quad screen and an oral glucose tolerance test were administered. The quad screen was negative. The oral glucose tolerance test result was 209, well above laboratory norms. Ms. Wren was asked to attend a diabetes class and to return to the clinic in one month.

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

Dr. Hamner saw Ms. Wren in the clinic on August 8 at 25 weeks, 6 days gestation. She reported having attended a class with the Dietician at the hospital. Fingerstick glucose level was 104, within normal limits, and Ms. Wren reported having normal blood sugar levels at home. Ms. Wren was asked to return in three weeks.

Dr. Hamner saw Ms. Wren again on August 29. At this time, she was at 26 weeks and 6 days gestation. Finger stick glucose on this occasion was elevated at 232 and Glyburide, a medication for diabetic control, was ordered. Ms. Wren weighed 350 pounds. Ms. Wren was asked to return in one week.

Ms. Wren did not return to the clinic until September 14. Dr. Hamner ordered a random blood sugar which was 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, 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 as requested.

Ms. Wren came back to the clinic on October 5, 2016. At this time, she was noted to be at 34 weeks gestation. Dr. Hamner made note of the patient's non-compliance and that she had not presented to the hospital for testing as requested. Ms. Wren explained that she could not be hospitalized as she had no babysitter. A random glucose level was high at 114 and Dr. Hamner referred Ms. Wren to the Labor & Delivery unit for testing.

On October 5, Ms. Wren was seen in the Labor & Delivery unit at BMH-DeSoto where she underwent a biophysical profile resulting in a score of 8/8. She underwent an ultrasound for assessment of gestational age and fetal weight. Estimated ultrasound gestational age was 36 weeks, 3 days $\pm$ 2 weeks and 4 days. Estimated fetal weight was 3009 grams $\pm$ 451.35 g. (6 pounds 10 ounce $\pm$ 11 pounds, 0 ounce).

Ms. Wren returned to the clinic on October 12. Dr. Hamner discussed the results of her recent ultrasound, BBP, and 24-hour urine testing. 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 into the record and Labetolol was ordered for blood pressure control.

Ms. Wren returned to the clinic on October 18 and her blood pressure was noted to be 147/95. A random glucose level was 126. Fetal non-stress was not reassuring. Dr. Hamner discussed the development of mild preeclampsia with Ms. Wren and he referred her to the Labor & Delivery unit at Baptist for additional testing. Ms. Wren was admitted to the Labor & Delivery unit at Baptist on October 18 where she underwent a biophysical profile with a score of 4/8. Estimate fetal weight via ultrasound was 3851g. $\pm$ 577.61 g (8 pounds 8 ounce $\pm$ 11 pounds 4 ounce). Average ultrasound again was noted to be 38 weeks and 2 days. A second biophysical profile was performed on October 19, which was read as 8/8.

Ms. Wren returned to the clinic on October 25 and Dr. Hamner noted gestational age to be 37 weeks. The non-stress test was reactive and a random glucose level was within normal limits at 48. On this visit, Dr. Hamner discussed induction of labor at 30 weeks and explained the risk 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 admission to BMH-DeSoto.

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 October 31 and noted that she had developed gestational diabetes and that she had been relatively non-compliant. He noted that ultrasound examination had suggested an infant thought to be large for gestational age. On physical examination, Ms. Wren was noted to be dilated 1 cm, 50% effaced at -3 station with membranes intact and vertex presentation. Fetal heart rate tracing was reassuring. Induction progressed throughout the day and fetal heart tones were monitored electronically. The fetal heart rate tracing was consistently assessed as a Category I by the nursing staff. Labor progressed well when at 1705, Dr. Hamner examined Ms. Wren and found that her cervix was completely dilated. No abnormalities of labor were encountered.

At 1723, the fetus presented in the OA position and shoulder dystocia was recognized. A gentle attempt at traction failed to resolve the dystocia. Multiple nurses were available to assist with the delivery. Ms. Wren was placed in the McRoberts position and suprapubic pressure was applied by the nursing staff. Dr. Hamner rotated the anterior shoulder to accomplish delivery at 1725.

APGAR scores were 3/7/8. The infant weighed 10 pounds, 15.3 ounces or 4970 g. Care of the child was assumed by the Neonatal Nurse Practitioner.

In all respects, the Obstetrical services provided by Dr. Hamner and the Southcrest Clinic was provided in compliance with all applicable standards of care. The child's injuries did not result from any breach of the standard of care by the defendants.

7. The following facts are established by the pleadings or by stipulation or admission.

   a. Monica Wren's pregnancy was under the medical care of Dabney Hamner, M.D. for her entire pregnancy and birth of SJD.

   b. A physician-patient relationship existed between Wren and Hamner throughout all relevant times.

   c. At all relevant times, Dr. Dabney Hamner was the agent and employee of Methodist LeBonheur Healthcare d/b/a Southwest Women's Healthcare.

8. The contested issues of fact are as follows:

   a. Whether Dr. Dabney Hamner was negligent in the care and treatment of Monica Wren and her daughter SJD at birth causing injury to SJD.

   b. The extent of injuries and damages suffered by SJD.

   c. What caused SJD's brachial plexus injury

   d. The resulting past medical expenses as a result of the shoulder injury.

e. The future medical expenses and lost value of occupational disability and lost value of household services.

9. The contested issues of law are as follows:

a. Is there a standard of care for obstetricians to follow under like or similar circumstances as faced by Dr. Hamner during the pregnancy and birth of SJD?

b. If so, was that standard of care breached?

c. Did Dr. Hamner breach the standard of care in the treatment he provided to Monica Wren?

d. If there was a breach in the standard of care, did that breach proximately cause injury to SJD?

e. Whether the minor Plaintiff will be allowed to participate in some sort of demonstration in the courtroom.

f. If the jury finds Dr. Hamner liable for medical negligence in the care and treatment of Monica Wren during her pregnancy and/or delivery of SJD, whether then Methodist LeBonheur Healthcare would be liable as his principal.

10. The following is a list and brief description of all exhibits (except documents to be used for impeachment only) to be offered in evidence by the respective parties. Each exhibit has been marked for identification.

A. **TO BE OFFERED BY THE PLAINTIFF:**

EXHIBIT	DESCRIPTION
P-1	BMH 24-316 – Baptist Memorial Hospital Desoto
P-2	BMH 317-888 – Baptist Memorial Hospital Desoto
P-3	BMH 889-1109 – Baptist Memorial Hospital Desoto
P-4	Southcrest 1-79 – Southcrest Women's Healthcare
P-5	Southcrest Ultrasound 1-8 – Southcrest Women's Healthcare
P-6	Deberry 235-237 – LeBonheur Children's Hospital
P-7	Deberry 238-242 – Senatobia Children's Clinic (Desoto Children's)
P-8	Deberry 243-287 – Senatobia Children's Clinic
P-9	Deberry 288-311 – LeBonheur Children's Hospital
P-10	Deberry 116-1231 – LeBonheur Portal Records
P-11	Deberry 1232 – SJD Photograph
P-12	Deberry 1233 – Birth Certificate
P-13	Deberry 1234-1246 – Howard Katz, M.D. Report and Affidavit (ID Only)
P-14	Deberry 1247-1261 – Hugh Ehrenberg, M.D. Report & Affidavit (ID Only)
P-15	Deberry 1298-1321 – Panola Medical Center (Tri-Lakes Medical)
P-16	Deberry 1322-1377 – MLH Clinic – ULPS Neurology

P-17	Deberry 1378-1516 – MLH Clinic – ULPS Cardiology
P-18	Deberry 1517-1555 – MLH Clinic – ULPS Campbell Orthopedics
P-19	Deberry 1556-1558 – Methodist Financial Services
P-20	Deberry 1559-1609 – C.T.S., LLC
P-21	Deberry 1610-1612 – Tri-Lakes Medical Center
P-22	Deberry 1613-1615 – UT Pediatrics
P-23	Deberry 1616-1707 – Tate County Health Department
P-24	Deberry 1708 – LeBonheur Children's Hospital
P-25	Deberry 1709-1710 – SJD Photographs
P-26	Deberry 1711-1713 – SJD Photographs
P-27	Deberry 1714 – SJD Video
P-28	Deberry 1715 – SJD Video
P-29	Deberry 1738-1810 – Brawner's Expert Reports (ID Only)
P-30	Deberry 1848-1874 – Brister's Economic Report (ID Only)
P-31	Deberry 1891-1900 – SJD Ultrasound Photographs
P-32	Deberry 1901-1932 – LeBonheur Children's Hospital
P-33	Deberry 1933 – Birthing Video
P-34	Deberry 1935-1967 – LeBonheur Heart Institute
P-35	Deberry 1968-1970 – LeBonheur Heart Institute
P-36	Deberry 1971 – LeBonheur Cerebral Palsy Clinic
P-37	Deberry 1972-1973 – Tate County Health Department
P-38	Deberry 1974-1975 – Tate County Health Department
P-39	Deberry 1976-1977 – Panola Medical Center
P-40	Deberry 1991-1999 – Baptist Memorial Hospital Desoto
P-41	Deberry 2000-2093 – UT Pediatric Hospital
P-42	Deberry 2094-2146 – C.T.S., LLC
P-43	Deberry 2147-2158 – Ally Physical Therapy
P-44	Deberry 2159-2210 – Endurance Physical Therapy (Athletico)
P-45	Deberry 2211-2215 – Endurance Physical Therapy (Athletico)
P-46	Deberry 2216-2273 – Desoto Children's Clinic
P-47	Deberry 2274-2281 – Endurance Physical Therapy (Athletico)
P-48	Deberry 2282-2285 – Methodist Healthcare
P-49	Deberry 2289-2291 – UT Pediatric Hospital
P-50	Deberry 2292-2324 – Endurance Physical Therapy (Athletico)
P-51	Deberry 2325-2340 – Howard Katz, M.D. Supplemental Report (ID Only)
P-52	Deberry 2341-2412 – Brawner Supplemental Reports (ID Only)
P-53	Deberry 2497-2504 – Endurance Physical Therapy (Athletico)
P-54	Deberry 2505-2531 – Brister Supplemental Report (ID Only)
P-55	ACOG Practice Bulletin Number 173, November 2016 (replaced Bulletin No.22)
P-56	ACOG Practice Bulletin Number 106, July 2009, Intrapartum Fetal Heart Rate
P-57	ACOG Practice Bulletin Number 107, August 2009, Induction of Labor
P-58	ACOG Practice Bulletin Number 156, December 2015, Obesity in Pregnancy

P-59	ACOG Practice Bulletin Number 101, February 2009, Ultrasonography in Pregnancy
P-60	ACOG Practice Bulletin Number 137, August 2013, Gestational Diabetes Mellitus
P-61	ACOG Hypertension in Pregnancy, 2013
P-62	Chatfield J. ACOG issues guidelines on fetal macrosomia. American College of Obstetricians & Gynecologists. Am Fam Physician. 2001 Jul 1;64(1):169-70. PMID: 11456432.
P-63	Chauhan SP, Gherman R, Hendrix NW, Bingham JM, Hayes E. Shoulder dystocia: comparison of the ACOG practice bulletin with another national guideline. Am J Perinatol. 2010 Feb;27(2):129-36. doi: 10.1055/s-0029-1224864. Epub 2009 Jun 29. PMID: 19565435.
P-64	Langer O, Berkus MD, Huff RW, Samueloff A. Shoulder dystocia: should the fetus weighing greater than or equal to 4000 grams be delivered by cesarean section? Am J Obstet Gynecol. 1991 Oct; =165(4 Pt 1):831-7. doi: 10.1016/0002-9378(91)90424-p. PMID: 1951539.
P-65	Hill MG, Cohen WR. Shoulder Dystocia: Prediction & Management. Women's Health. March 2016:251-261. doi: 10.2217/whe.15.103.
P-66	Mansor A, Arumugam K, Omar SZ. Macrosomia is the only reliable predictor of shoulder dystocia in babies weighing 3.5 kg or more. Eur J Obstet Gynecol Reprod Biol. 2010 Mar;149(1):44-6. doi: 10.1016/j.ejogrb.2009.12.003. Epub 2009 Dec 29. PMID: 20042263.
P-67	Belfort MA, Dildy GA, Saade GR, Suarez V, Clark SL. Prediction of shoulder dystocia using multivariate analysis. Am J Perinatol. 2007 Jan;24(1):5-10. doi: 10.1055/s-2006-954956. Epub 2006 Dec 27. PMID: 17195152.
P-68	Acker DB, Sachs BP, Friedman EA. Risk factors for shoulder dystocia. Obstet Gynecol. 1985 Dec;66(6):762-8. PMID: 4069477.
P-69	Raio L, Ghezzi F, Di Naro E, Buttarelli M, Franchi M, Dürig P, Brühwiler H. Perinatal outcome of fetuses with a birth weight greater than 4500 g: an analysis of 3356 cases. Eur J Obstet Gynecol Reprod Biol. 2003 Aug 15;109(2):160-5. doi: 10.1016/s0301-2115(03)00045-9. PMID: 12860334.
P-70	Gabbe, Obstetrics, Normal and Problem Pregnancies, Chapter 13, section titled Abnormal Labor and Induction of Labor.
P-71	Gabbe, Obstetrics, Normal and Problem Pregnancies, Chapter 17, page 447 in section titled Shoulder Dystocia, the text cites Acker who found "the relative probability of shoulder dystocia in the 7 percent of infants weighing more than 4000 g was 11 times greater than average and in the 2 percent of infants weighing more than 4500 g it was 22 times greater."
P-72	https://www.mombaby.org/wp-content/uploads/2019/10/Macrosomia-Delivery-Planning-Final.pdf.
P-73	Ray JG, Vermeulen MJ, Shapiro JL, Kenshole AB. Maternal and neonatal outcomes in pregestational and gestational diabetes mellitus, and the influence of maternal obesity and weight gain: the DEPOSIT study. Diabetes Endocrine

	Pregnancy Outcome Study in Toronto. QJM. 2001 Jul;94(7):347-56. doi: 10.1093/qjmed/94.7.347. PMID: 11435630.
P-74	McFarland LV, Raskin M, Daling JR, Benedetti TJ. Erb/Duchenne's palsy: a consequence of fetal macrosomia and method of delivery. Obstet Gynecol. 1986 Dec;68(6):784-8. PMID: 3785790.
P-75	King JR, Korst LM, Miller DA, Ouzounian JG. Increased composite maternal and neonatal morbidity associated with ultrasonographically suspected fetal macrosomia. J Matern Fetal Neonatal Med. 2012 Oct;25(10):1953-9. doi: 10.3109/14767058.2012.674990. Epub 2012 Apr 17. PMID: 22439605.
P-76	Lewis DF, Edwards MS, Asrat T, Adair CD, Brooks G, London S. Can shoulder dystocia be predicted? Preconceptive and prenatal factors. J Reprod Med. 1998 Aug;43(8):654-8. PMID: 9749414.
P-77	Al-Khaduri MM, Abudraz RM, Rizvi SG, Al-Farsi YM. Risk factors profile of shoulder dystocia in oman: a case control study. Oman Med J. 2014;29(5):325-329. doi:10.5001/omj.2014.88.
P-78	Modanlou HD, Komatsu G, Dorchester W, Freeman RK, Bosu SK. Large-for-gestational-age neonates: anthropometric reasons for shoulder dystocia. Obstet Gynecol. 1982 Oct;60(4):417-23. PMID: 7121926.
P-79	Nesbitt TS, Gilbert WM, Herrchen B. Shoulder dystocia and associated risk factors with macrosomic infants born in California. Am J Obstet Gynecol. 1998 Aug;179(2):476-80. doi: 10.1016/s0002-9378(98)70382-5. PMID: 9731856.
P-80	Øverland EA, Vatten LJ, Eskild A. Pregnancy week at delivery and the risk of shoulder dystocia: a population study of 2,014,956 deliveries. BJOG. 2014 Jan;121(1):34-41. doi: 10.1111/1471-0528.12427. Epub 2013 Sep 10. PMID: 24020942.
P-81	Overland EA, Vatten LJ, Eskild A. Risk of shoulder dystocia: associations with parity and offspring birthweight. A population study of 1 914 544 deliveries. Acta Obstet Gynecol Scand. 2012 Apr;91(4):483-8. doi: 10.1111/j.1600-0412.2011.01354.x. Epub 2012 Feb 22. PMID: 22356510.
P-82	Robinson H, Tkatch S, Mayes DC, Bott N, Okun N. Is maternal obesity a predictor of shoulder dystocia? Obstet Gynecol. 2003 Jan;101(1):24-7. doi: 10.1016/s0029-7844(02)02448-1. PMID: 12517641.
P-83	Gurewitsch ED, Allen RH. Reducing the risk of shoulder dystocia and associated brachial plexus injury. Obstet Gynecol Clin North Am. 2011 Jun;38(2):247-69, x. doi: 10.1016/j.ogc.2011.02.015. PMID: 21575800.
P-84	Chauhan SP, Rose CH, Gherman RB, Magann EF, Holland MW, Morrison JC. Brachial plexus injury: a 23-year experience from a tertiary center. Am J Obstet Gynecol. 2005 Jun;192(6):1795-800; discussion 1800-2. doi: 10.1016/j.ajog.2004.12.060. PMID: 15970811.
P-85	Mehta SH, Blackwell SC, Hendler I, Bujold E, Sorokin Y, Ager J, Kraemer T, Sokol RJ. Accuracy of estimated fetal weight in shoulder dystocia and neonatal birth injury. Am J Obstet Gynecol. 2005 Jun;192(6):1877-80; discussion 1880-1. doi: 10.1016/j.ajog.2005.01.077. PMID: 15970839.

P-86	Ehrenberg HM. Intrapartum considerations in prenatal care. Semin Perinatol. 2011 Dec;35(6):324-9. doi: 10.1053/j.semperi.2011.05.016. PMID: 22108081.
P-87	Responses & Objections of the Defendants, Dabney Hamner, M.D. and Methodist LeBonheur Healthcare d/b/a Southcrest Women's Healthcare to the Plaintiff's Interrogatories (First Set) (1/22/2021)
P-88	Answers of the Defendant, Dabney Hamner, M.D. to the Plaintiff's Second Set of Interrogatories (3/23/2021)
P-89	Answers of Dr. Dabney Hamner to the Plaintiff's Interrogatories Numbered 11-27 (Second Set) (11/8/2021)
P-90	Supplemental Answer of Dr. Dabney Hamner to the Plaintiff's Interrogatory No. 17 (11/10/2021)
P-91	Amended Second Supplemental Answer of Dr. Dabney Hamner to the Plaintiff's Interrogatory No. 17 (11/16/2021)
P-92	Any exhibit to be offered by Defendants.

The authenticity and admissibility in evidence of these exhibits has been stipulated. If the authenticity and/or admissibility of any exhibit is objected to, the exhibit must be identified in the following space, together with a statement of the specific ground or grounds for the objection.

Defendants' Objections:

Defendants make the following objections to Plaintiffs' proposed exhibits:

NO	OBJECTION
P-34	Relevance
P-35	Relevance
P-55-86	ID Only. See MRE 803(18)
P-87-92	All objections reserved

B. TO BE OFFERED BY THE DEFENDANTS:

EXHIBIT	DESCRIPTION	
D-1	Southcrest Women's Healthcare -M. Wren	Southcrest 0001-0079
D-2	Southcrest Women's Healthcare Ultrasound -M.Wren	Southcrest Ultrasound 001-008
D-3	May's Pharmacy-Wren Records	May's-Wren 001-006
D-4	May's Pharmacy-WJD Records	May's-SJD 001-002
D-5	DeSoto Children's Clinic	DCC001-043
D-6	Shoulder Dystocia illustration a. Shoulder Dystocia b. McRoberts Maneuver c. Suprapubic pressure	
D-7	Deberry Records – (Produced by Plaintiff) a. Baptist Memorial Hospital DeSoto	Deberry 4-234

	b. Senatobia Children's Clinic	Deberry 243-287
	c. LeBonheur Children's Hospital	Deberry 288-311
	d. Dabney Hamner, M.D. 3/23/2020 Visit	Deberry 312-331
	e. Dabney Hamner, M.D. 4/6/2020 Visit	Deberry 341-349
	f. Dabney Hamner, M.D. 4/17/2020 Visit	Deberry 350-372
	g. Baptist Memorial Hospital-Monica Wren	Deberry 384-801
	h. Baptist Memorial Hospital-Sariyah Deberry	Deberry 801-1000
	i. Baptist Memorial Hospital-Monica Wren	Deberry 1001-1115
	j. LeBonheur Children's Hospital	Deberry 116-1231
	k. Photograph	Deberry 1232
	l. Birth Certificate	Deberry 1233
	m. Tri-Lakes Medical Center (Panola MC)	Deberry 1298-1321
	n. UT LeBonheur Pediatric Neurology	Deberry 1322-1377
	o. UT LeBonheur Pediatric Cardiology	Deberry 1378-1516
	p. UT LeBonheur Pediatric Campbell Ortho.	Deberry 1517-1555
	q. C.T.S., LLC	Deberry 1559-1609
	r. Tri-Lakes Medical Center	Deberry 1298-1321
	s. Tate County Health Department	Deberry 1616-1707
	t. LeBonheur Children's Hospital	Deberry 1708
	u. Photographs April-May 2021	Deberry 1709-1710
	v. Photographs	Deberry 1711-1713
	w. May 29, 2020 video	Deberry 1714
	x. July 28, 2020 video	Deberry 1715
	y. Ultrasound photos of Sariyah Deberry	Deberry 1891-1900
	z. LeBonheur Children's Hospital	Deberry 1901-1932
	aa. Demonstrative Animation Exhibit	Deberry 1933
	bb. UT LeBonheur Pediatric Cardiology	Deberry 1935-1970
	cc. Baptist Memorial Hospital DeSoto	Deberry 1995-1999
	dd. UT LeBonheur Pediatric	Deberry 2000-2093
	ee. C.T.S., LLC	Deberry 2097-2146
	ff. Ally Physical Therapy	Deberry 2150-2158
	gg. Endurance Physical Therapy	Deberry 2159-2210
	hh. DeSoto Children's Clinic	Deberry 2225-2273
	ii. Methodist Radiology	Deberry 2282-2285
	jj. Endurance Physical Therapy (Athletico)	Deberry 2292-2324
D-8	Baptist Memorial Hospital Records (Produced by the Co-Defendantn)	
	a. Baptist Memorial Hospital DeSoto – M. Wren	D-BMH-D 1-572
	b. Baptist Memorial Hospital DeSoto-M.Wren-FMS	D-BMH-FMS 1-221
	c. Baptist Memorial DeSoto- S. Deberry	D-BMH-D 1-293
D-9	CV of Dabney Hamner, M.D.	
D-10	CV of J. Martin Tucker, M.D.	
D-11	CV of Collette C. Parker, M.D.	
D-12	ACOG Practice Bulletin No. 40, Shoulder Dystocia; Nov. 2007: 682-687 (ID only)	

D-13	A Comparison of Obstetric Maneuvers for the Acute Management of Shoulder Dystocia; Hoffman, et al; Obstet Gynecol, June 2011: 1-13 (ID only)
D-14	Neonatal Brachial Plexus Palsy; ACOG/AAP, 2014 (ID only)
D-15	Shoulder Dystocia: The Unpreventable Obstetric Emergency With Empiric Management Guidelines; Gherman, et al; Am J Obstet Gynecol, (2006): 657-672 (ID only)
D16	Shoulder Dystocia: Are Historic Risk Factors Reliable Predictors? Ouzounian and Gherman; Am J Obstet Gynecol, (2005): 192, 1933-1938 (ID only)
D-17	A Comparison of Glyburide and Insulin in Women with GDM; NEJM Vol. 343, No. 16; October 19, 2000 (ID only)
D-18	Brachial Plexus Palsy: An In Utero Injury? Gherman, et al; Am J Obstet Gynecol, May 1999: 1303-1307 (ID only)
D-19	Severe Brachial Plexus Palsy in Women Without Shoulder Dystocia; Torki, et al; Obstetrics and Gynecology, Vol. 120, No. 3, Sept. 2012:539-541 (ID only)
D-20	Controversies Surrounding the Causes of Brachial Plexus Injury; H.F. Sandmire, R.K. Demott, International Journal of Gynecology and Obstetrics, 104 (2009): 9-13 (ID only)
D-21	Neonatal Brachial Plexus Palsy: What We Know About Causation; Lerner H; www.obmanagement.com, Vol. 26, No. 10, October 2014:43-52 (ID only)
D-22	A Case of Klumpke's Obstetric Brachial Plexus Palsy Following a Cesarean Section; Al-Quottan and El-Sayed, Clin Case Rep, Sept. 2015 (ID only)
D-23	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 (ID only)
D-24	Isolated Lower Brachial Plexus (Klunpke) Palsy With Compound Arm Presentation: Case Report; EP Buchanan et al, JHS Vol. 3 8A, August 2013: 1567-1570 (ID only)
D-25	Neurology of the Newborn, 6th Ed, Volpe, et al, Chapter 36, page 1108 (ID only)
D-26	ACOG Practice Bulletin No. 176; December 2016: Ultrasound in Pregnancy (ID only)
D-27	ACOG Practice Bulletin No. 101; February, 2009; Ultrasound in Pregnancy (ID only)
D-28	Diabetes Research and Clinical Practice 76 (2007) 474-475 (ID only)
D-29	ACOG Practice Bulletin No. 178; May, 2017; Shoulder Dystocia (ID only)
D-30	Erb's Palsy Without Shoulder Dystocia, Sandmire, Int'l J of GYN & OB (2002) 235-256 (ID only)
D-31	Brachial Plexus Palsy Associated with Cesarean Section: An In Utero Injury; Gherman, Am J Ob-Gyn 177, No. 5, 1977 (ID only)
D-32	Induction of Labor, ACOG Practice Bulletin No. 107; August 2009 (ID only)
D-33	Management of Intrapartum Fetal Heart Rate Tracings, ACOG Practice Bulletin No. 116; November 2010 (ID only)
D-34	Glyburide for the Management of Gestational Diabetes; AJOG (2006) 195, 1090-4 (ID only)
D-35	Baby and pelvis photos (1-5 (ID only)

The authenticity and admissibility in evidence of these exhibits has been stipulated. If the authenticity and/or admissibility of any exhibit is objected to, the exhibit must be identified in the following space, together with a statement of the specific ground or grounds for the objection.

Plaintiff's Objections:

Plaintiffs make the following objection to Defendants' proposed exhibits:

NO	OBJECTION
D-9	Redundant and hearsay
D-10	Redundant and hearsay
D-11	Redundant and hearsay

11. Expert witnesses are expected to be called by the parties, as follows:

A. EXPERT WITNESSES TO BE CALLED LIVE BY THE PLAINTIFF:

The following is a list of expert witnesses PLAINTIFF anticipate calling live at trial (including witnesses used solely for impeachment):

NAME	WILL/MAY CALL	LIABILITY/DAMAGES
Hugh M. Ehrenberg, M.D.	May	Liability/Damages
Howard Katz, M.D.	May	Liability/Damages
Bruce Brawner, LCP	May	Damages
Bill M. Brister, Ph.D.	May	Damages

The qualifications of the above listed expert witnesses are admitted by defendants except as follows:

B. EXPERT WITNESSES TO BE CALLED BY PLAINTIFF VIA DEPOSITION

The following expert witnesses will/may testify in the trial of this matter for the plaintiff(s) via deposition: **None**

All objections to depositions and/or testimony contained in depositions, video or otherwise, evidentiary or otherwise, must be presented to the undersigned trial judge in writing no later than 30 days prior to the scheduled date of trial. Failure to present such objection as required herein shall constitute a waiver of such objections.

C. EXPERT WITNESSES TO BE CALLED LIVE BY DEFENDANTS:

The following is a list of expert witnesses DEFENDANTs anticipate calling live at trial, (excluding witnesses used solely for impeachment).

NAME	WILL/MAY CALL	LIABILITY/DAMAGES
Dabney Hamner, M.D.	Will Call	L/D

Marty Tucker, M.D.	Will Call	L/D
Collette Parker, M.D.	May Call	D
Rusty Yerkes, Ph.D.	May Call	D

Plaintiff's Objections:

The qualifications of the above-listed expert witnesses are admitted by plaintiff except as follows: **Objects to Dr. Colette Parker relative to vocational subjects.**

D. EXPERT WITNESSES TO BE CALLED BY DEFENDANT VIA DEPOSITION:

The following expert witnesses will/may testify in the trial of this matter for the defendant(s) *via* deposition: None

All objections to depositions and/or testimony contained in depositions, video or otherwise, evidentiary or otherwise, must be presented to the undersigned trial judge in writing no later than 30 days prior to the scheduled date of trial. Failure to present such objections as required herein shall constitute a waiver of such objections.

12. Lay witnesses are expected to be called by the parties, as follows:

A. LAY WITNESSES TO BE CALLED BY PLAINTIFF:

Those witnesses whom the PLAINTIFF will/may call live to testify in the trial of this matter, excluding those expert witnesses identified in ¶11 above, are as follows:

NAME	WILL/MAY CALL	LIABILITY/DAMAGES
Monica Wren	Will	Liability/Damages
Joyce Wren	May	Liability/Damages
Benson Deberry	May	Liability/Damages
Dabney Hamner, M.D.	May	Adverse

Plaintiff reserves the right to call any of the following previously disclosed lay witnesses but at this time does not anticipate doing so:

B. LAY WITNESSES TO BE CALLED BY PLAINTIFF *VIA* DEPOSITION:

Those witnesses whom the PLAINTIFF will/may call *via* deposition to testify in the trial of this matter, excluding those expert witnesses identified in ¶11 above, are as follows: **Possibly Dr. Dabney Hamner if needed.**

All objections to depositions and/or testimony contained in depositions, evidentiary or otherwise, and including objections reserved during the taking of the deposition, must be presented to the undersigned trial judge in writing no later than 30 days prior to the

scheduled date of trial. Failure to present such objections as required herein shall constitute a waiver of such objections.

A. LAY WITNESSES TO BE CALLED BY DEFENDANT:

Those witnesses whom the DEFENDANT will/may call live to testify in the trial of this matter, excluding those expert witnesses identified in ¶11 above, are as follows:

NAME	WILL/MAY CALL	LIABILITY/DAMAGES
Monica Wren	May	D
Joyce Wren	May	D
Benson Deberry	May	D

B. LAY WITNESSES TO BE CALLED BY DEFENDANT *VIA* DEPOSITION:

Those witnesses whom the DEFENDANT will/may call *via* deposition to testify in the trial of this matter, excluding those expert witnesses identified in ¶11 above, are as follows:

NAME	WILL/MAY CALL	LIABILITY/DAMAGES
Monica Wren	May	D
Joyce Wren	May	D
Benson Deberry	May	D

All objections to depositions and/or testimony contained in depositions, evidentiary or otherwise, and including objections reserved during the taking of the deposition, must be presented to the undersigned trial judge in writing no later than 30 days prior to the scheduled date of trial. Failure to present such objections as required herein shall constitute a waiver of such objections.

13. The following is a list and brief description of charts, graphs, models, schematic diagrams, and similar objects which will be used in opening statements or closing arguments but **will not** be offered in evidence:

A. BY THE PLAINTIFF:

i. Plaintiff may use a Power Point during voir dire, opening, closing, and the examination of any witness.

ii. Plaintiff may use an enlargement of any exhibit.

iii. Plaintiff may use a damages summary board.

iv. Plaintiff may use a flip chart.

v. Deberry 1933 – Birthing Video.

vi. https://www.mombaby.org/wp-content/uploads/2019/10/Macrosomia-Delivery-Planning-Final.pdf.

vii. Plaintiff may use any of Defendants' Trial Visual Aids.

viii. Plaintiff may use medical illustrations.

*The Defendants reserve objection to any PowerPoint, Visual Aid or Damages Board not produced in Discovery.

B. BY THE DEFENDANTS:

i. Defendant may use a Power Point during voir dire, opening, closing, and the examination of any witness.

ii. Defendant may use an enlargement of any exhibit.

iii. Defendant may use a flip chart to have expert witnesses illustrate/explain their testimony.

iv. Defendant may use medical illustrations produced during discovery.

*The Plaintiff reserves objection to any PowerPoint, flip chart, or medical illustrations not produced in Discovery.

14. Counsel suggests the following additional matters and/or preliminary hearings to aid in disposition of the action:

None identified at this time.

15. Counsel estimates the length of the trial will be **5** days.

16. The e-mail addresses for all lead counsel are as follows:

Plaintiff:	David C. Dunbar	dcdunbar@dunbarmonroe.com
	Kim D. McCormack	kmccormack@dunbarmonroe.com
	Tina M. Bullock	tina@bwmlaw.com
	Wm. Wes Fulgham	wes@bwmlaw.com
Defendants:	Tommie Williams	twilliams@upshawwilliams.com
	Tommie Williams, Jr.	twilliamsjr@upshawwilliams.com

This Pre-Trial Statement is hereby submitted, this the 22nd day of September, 2023.

David Dunbar
Attorney for Plaintiff

Tommie Williams
Attorney for Defendants

Approved for filing this the 25th day of September, 2023.

Gerald Chatham, Sr., Circuit Judge