

Three Typical Claims in Shoulder Dystocia Lawsuits

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At the end of a busy day, your office manager comes in holding a thick envelope. You don't like the look on her face. As she hands it to you, you see the return address is a law firm. The envelope holds a summons indicating that a malpractice lawsuit is being filed against you. The name of the patient involved seems only vaguely familiar. When you review the chart, you see that it was a delivery with a mild shoulder dystocia—four years ago.

As an obstetrician who has been in practice for more than 28 years, had numerous shoulder dystocia deliveries, and reviewed close to 100 shoulder dystocia medical-legal cases, I have seen the above scenario played out frequently. In some cases, the delivery was catastrophic and the obstetrician was unsurprised by the lawsuit. In most cases, however, the delivery was just one of hundreds or thousands the doctor has done over the years...and forgotten. Whatever the circumstances, the receipt of this suit letter will initiate a years-long process with which, unfortunately, obstetricians are too familiar.

The Three Most Common Claims

It is worthwhile to examine the three types of claims most commonly made in shoulder dystocia lawsuits, how they are “packaged” by plaintiffs’ attorneys, and what might make such claims valid or fallacious. Understanding this may help physicians (and their defense teams) determine when a plaintiff’s claim has validity—and should be settled expeditiously—and when such claims are not valid. Such understanding will also lead to the best approaches for countering nonvalid claims.

Almost all shoulder dystocia malpractice suits imply that the delivery was *mishandled* by the obstetrician or midwife. By far the most common type of injury leading to suit is a brachial plexus injury, resulting in some degree of permanent paralysis of one or both shoulders, arms, or hands of the infant. However, some suits claim neurologic damage due to asphyxia at the time of delivery, or even fetal death.

The three most commonly claimed deviations from the standard of care are as follows:

1. The physician/midwife should have been able to predict that a shoulder dystocia was going to occur.

Allegation

Given certain risk factors (*claimed* to have been present and to indicate an increased risk), the clinician should have known that a shoulder dystocia was likely to occur. Knowing this, the clinician should have avoided this risk by performing an elective cesarean section, or should have interrupted labor at some point and delivered the baby surgically.

The plaintiff’s lawyer and expert witnesses will *claim* that it was the physician’s duty to assess whether the baby was at increased risk for shoulder dystocia at delivery. Plaintiffs will enumerate a series of factors gleaned from their history and medical records which they will *claim* indicate that they were at increased risk for shoulder dystocia. Such factors include:

Prelabor risks (alleged):

- Suspected big baby
- Gestational diabetes
- Large maternal weight gain
- Large uteri fundal height measurement
- Small pelvis
- Small maternal stature
- Previous large baby
- Known male fetus

Risks during labor (alleged):

- Arrest of first stage of labor
- Deceleration of end of first stage of labor
- Prolonged second stage of labor
- Use of pitocin
- Use of either vacuum or forceps for delivery
- Tasks plaintiffs claim the clinician had a duty to perform
- Obtaining an ultrasound in the last few weeks of pregnancy to assess fetal weight
- Assessment of blood sugars throughout pregnancy (beyond indicated ACOG guidelines)

Facts

In fact, careful evaluation indicates that there are only five, literature-supported, risk factors for shoulder dystocia:

- history of previous shoulder dystocia,
- macrosomia,
- gestational diabetes,
- small maternal stature, and
- use of vacuum or forceps at delivery.

All other alleged factors either are not consistently linked with shoulder dystocia or are based on fetal macrosomia.

Defense

The key to refuting such claims involves:

1. Being familiar with the literature on shoulder dystocia as expressed in textbooks, ACOG bulletins, and significant journal articles.
2. Knowing that even with the valid risk factors, “risk” is a relative term. A given risk factor could produce a 10 percent increase in risk or a 10-fold increase. Never let a plaintiff’s attorney concatenate a series of risks factors without having him or her define—or having you

tell him or her—exactly what *percentage* increase risk is involved with each factor. Contend any statement that a certain factor is a risk factor if the literature shows it is not. Also, be sure to point out what the sensitivity and false positive value of each risk factor is, in order to put each in context as a clinical predictive tool.

3. Always remember that shoulder dystocia in and of itself is not the risk with which a physician has to be primarily concerned in deciding which mode of delivery to recommend to a patient. The key factor is the risk of *permanent brachial plexus injury*.

Shoulder dystocias occur in about one percent of all deliveries, with the percentage rising for babies over 4,000g (10 percent) and 4,500g (20 percent). Brachial plexus injuries, in general, occur in 10 percent of all shoulder dystocia deliveries. Of these, only 10 percent remain permanent. So, although the risk of a patient encountering a shoulder dystocia may range from 1–20 percent, the risk of her fetus experiencing a permanent brachial plexus injury is approximately 1/100th of that. Published studies (Rouse) show that even in the highest risk patients—those with macrosomic babies and gestational diabetes—the risk of permanent brachial plexus injury is only 1 in 450.¹ While this number is higher than the risk of permanent brachial plexus injury in the general population (1 in 10,000), it still means that 99.8 percent of babies in this highest risk category would not experience a permanent brachial plexus injury via vaginal delivery. Jurors may need to be taught that this fetal risk must be weighed against the risk involved in the performance of an elective cesarean section, especially when the mother is obese, has diabetes, or has other risk factors that patients at high risk for shoulder dystocia often do.

Thus, in refuting the first of the common shoulder dystocia claim, the defense team must know which of the claimed risk factors are valid and must determine, based on a given patient's medical history, her specific predelivery risk for permanent brachial plexus injury. This number is what needs to be presented to the jury when arguing whether or not a cesarean section should have been offered.

2. There were enough risk factors present that the mother should have been given the option of having a cesarean section.

Although this claim involves several of the items discussed above, the specific import here is the issue of informed consent.

Allegation

The plaintiff will claim that, in general, mothers will do everything possible to ensure the safety of their infants. ACOG documents will be quoted relating to patient's rights to be notified of risks. It will further be claimed that, had the patient

in this case only known that there was *any* risk of injury to her child, she would of course have opted for cesarean section. Therefore the physician or midwife was negligent in not specifically discussing the risk of shoulder dystocia with his or her patient and not having offered a cesarean section as an option for delivery.

Defense

The legitimate and proper responses to this claim are:

1. Evaluate the factors claimed by the plaintiff to see if they are, in fact, genuine risks.
2. Demonstrate that the standard of care is *not* to discuss all risks with patients. For instance, if the risk of having a serious car accident on the way to the hospital while in labor is 1 in 10,000, it would not be obligatory for the physician to warn the patient about this and to offer her another means of transportation. Similarly, if the risk of a permanent brachial plexus injury—not just of a shoulder dystocia occurring—in a specific case is relatively rare, then it is not necessarily a physician's obligation to discuss this risk with his or her patient. In the same vein, a physician is not obliged to discuss the rare risks of amniotic fluid embolus or postpartum hemorrhage leading to hysterectomy for each and every one of his or her obstetrical patients.
3. There is a general consensus—documented in surgical textbooks²—that the level of risk at which a physician is obliged to discuss the possibility of a complication with his or her patient is roughly 1 in 100. As noted above, even in the most high-risk cases, the risk of permanent brachial plexus injury does not exceed 1 in 450.

This does not mean that, for a patient with gestational diabetes and a suspected very large baby, no consideration should be given to discussing cesarean section. Neither does it mean that one should blithely perform instrumental vaginal deliveries on such patients. What it does mean, however, is that exaggerated claims of the physician's duty to inform a patient about rare risks are neither truthful nor the standard of care.

3. The permanent brachial plexus injury suffered by the plaintiff could only have occurred because the doctor pulled too hard when encountering a shoulder dystocia and did not act according to the standard of care by correctly performing other maneuvers.

Allegation

With this claim, the plaintiff's lawyer is invoking the hoary old legal theory of *res ipsa loquitur*: the thing speaks for itself. The lawyer and his or her expert witnesses will *claim* that all permanent brachial plexus injuries are due to "excessive" trac-

tion. They will *claim* that this is, physiologically, the only way such injuries can occur. They may *claim* that, had a physician performed all the proper maneuvers, the “excessive force” they say was used would not have been necessary and thus the baby would not have suffered the injury it did.

Defense

This is the most difficult of all of the three claims to refute. The jury is presented with a child who has a permanent injury. From what they are told by the plaintiff’s obstetrical, neurological, and neurosurgical expert witnesses, it makes a certain amount of sense that the injury was caused by the delivering clinician’s actions in pulling on the fetal head in an improper way in an attempt to resolve the shoulder dystocia.

The refutation of such claims involves showing that there are no data to support them; they are, in fact, totally unproven. No reliable study has shown a linkage between traction applied to the fetal head and permanent brachial plexus injury, much less that *all* such injuries are based on clinician traction. Furthermore, much evidence can be presented that contradicts the assumption that all permanent brachial plexus injuries are due to excessive physician force, for example:

- documented cases exist of permanent brachial plexus injuries that involved no shoulder dystocia;
- likewise, cases of permanent brachial plexus injuries following cesarean section deliveries have been noted;
- the forces of labor and maternal expulsive efforts themselves can cause stretching of the brachial plexus;
- the forces of labor and maternal expulsive efforts themselves generate pressure on the brachial plexus four to nine times higher than that exerted by a physician;³ and
- recent eyewitness and/or video documentation exists of two deliveries, one involving a temporary and one involving a permanent brachial plexus injury, where there was a) no shoulder dystocia and b) no physician contact with the baby at birth.⁴ Thus, claims by plaintiffs’ attorneys and their physician expert witnesses that excessive physician traction is the only etiology of permanent brachial plexus injuries can not be substantiated.

A further caution: never allow the pejorative term “excessive traction” to go unchallenged. Excessive means “too much.” Yet a permanent brachial plexus injury may and frequently does occur with the clinician applying what he or she perceives as the same amount of force he or she uses for all deliveries. Given other forces involved in the delivery process and the biologic variability of each infant for susceptibility to brachial plexus injury, a claim that a particular brachial plexus injury is the result of an inappropriate amount of force being used by the deliverer—except in the rarest cases of documented extraordinary traction—is unproven and untenable.

An Uphill Battle

Medical legal cases involving shoulder dystocia and brachial plexus injuries are among the most challenging faced by physicians and their defense teams. It is often an uphill battle convincing a lay jury that a young child facing a lifetime disability should not be awarded money whether or not negligence was involved. Furthermore, when payouts at jury trials do occur, they are often in the \$1–\$3 million range, enough to make many insurance companies shy away from taking shoulder dystocia cases to trial. This is unfortunate, because experience shows that, when an adequately prepared defense team with knowledgeable expert witnesses and a physician who can convincingly show that he or she provided excellent care presents its case, outcomes are overwhelmingly favorable for the defense. ■

References

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