PATIENT SAFETY AND RISK MANAGEMENT IN OBSTETRICS AND OBSTETRICS MALPRACTICE
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SHOULDER DYSTOCIA AND OBSTETRIC LIABILITY: EFFECTIVELY AVOIDING LITIGATION

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1. Introduction

In Kungl v. Fallis[1], Justice Callaghan made the following comment:

> **Birth is a very traumatic event. It is dangerous for the baby. The birth process, even under optimal conditions, is potentially a traumatic crippling event for the baby.**

For most women, the birth process, although difficult, is an exciting and life-changing experience. The emergence of a healthy baby after many hours of intense labour is truly a miraculous event. For some, however, the experience can be extremely frightening particularly when complications arise. One such complication is shoulder dystocia which, if improperly managed, can have disastrous consequences.

2. What is Shoulder Dystocia?

Shoulder dystocia occurs when the shoulders of the fetus become trapped behind the mother's pubic bone or pelvic inlet following delivery of the head[2]. Improper management of shoulder dystocia can have disastrous consequences for the mother and the fetus. Some of the complications that can arise from shoulder dystocia include, brachial plexus injury[3], erbs palsy[4], Klumpke's palsy[5], clavicular or humeral fractures, fetal asphyxia, fetal death or meconium aspiration[6].

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[1] Kungl v. Fallis, [1989] O.J. No. 15

[2] Sturdee, D., Otal K. and Keane D., Yearbook of Obstetrics & Gynecology, Volume 9. 2001 Royal College of O & G Press, London.

[3] Brachial palsy is a paralysis or weakness of the arm caused by damage to the brachial plexus. The brachial plexus is the network of spinal nerves (from the lower neck and upper shoulder) that supply the arm, forearm, and hand with movement and sensation. In a brachial plexus injury generally all five nerves of the brachial plexus are implicated resulting in paralysis of the entire arm. (http://www.nlm.nih.gov/medlineplus/ency/article/002239.htm)

[4] Erb's palsy is a paralysis of the fifth and sixth cervical nerves (the upper brachial plexus) which usually affects the upper arm and rotation of the lower arm. (http://www.nlm.nih.gov/medlineplus/ency/article/002239.htm)

[5] Klumpke palsy is a paralysis of the seventh and eighth cervical and first thoracic nerves (lower brachial plexus) which usually affects the hand. (http://www.nlm.nih.gov/medlineplus/ency/article/002239.htm)

[6] Meconium is the medical term for the first feces of the newborn. Aspiration occurs when the newborn inhales the meconium mixed with amniotic fluid either in the uterus or just after delivery. (http://www.nlm.nih.gov/medlineplus/ency/article/002239.htm)

3. Medical Malpractice

In a medical malpractice action, the plaintiff must prove that the defendants failed to exercise the reasonable degree of skill and knowledge and the reasonable degree of care expected of a normal, prudent physician of the same experience and standing.

The defendant's conduct is to be judged in light of the knowledge that ought to have been reasonably possessed at the time of the alleged acts of negligence[7]. Medical science is a constantly developing and evolving field of practice and the courts have accordingly held that, a defendant is not to be judged with the benefit of hindsight but in light of the prevailing standards of professional knowledge at the material time.[8]

If a defendant physician holds him or herself out as a specialist, possessing special knowledge or expertise in a specific field, a higher degree of skill may be required of that defendant physician[9]. An obstetrician may therefore be held to a different standard than a family physician with respect to the management of pregnancy and subsequent delivery of the newborn infant.

The first step in a medical malpractice action is to establish the requisite standard of care. Expert evidence is most often employed to provide the court with guidance as to what constitutes the appropriate standard of care in the circumstances.

In obstetrical negligence cases such as those that may arise from shoulder dystocia, it is essential to retain medical experts to comment upon the standard of care provided to the plaintiff in the pre- and perinatal stages.

It is also necessary to obtain an opinion from an expert with appropriate pediatric expertise such as a neonatologist or pediatric neurologist. The choice of an expert will, of course, depend on the nature of the injuries sustained by the infant. It must be noted that, although expert opinion

[7] *ter Neuzen v. Korn,* (1995) 3 S.C.R. 675 at 696-7

[8] *Roe v. Ministry of Health,* [1954] 2 All E.R. 131 (C.A.)

[9] *Crits and Crits v. Sylvester et. al* (1956) 1, D.L.R. (2d) 502 (Ont. C.A.), aff'd (1956), 5 D.L.R. (2d) 601, [1956] S.C.R. 1991 (S.C.C.)

serves as a guide to the court, the ultimate determination of the required standard of care in the relevant circumstances of the case rests in the hands of the trier of fact.[10]

In medical malpractice actions, the standard of care may be influenced by the forseeable risk of the injury. Thus, the higher the risk inherent in the treatment and care provided to the plaintiff, the higher the standard of care that may be expected of the defendant physician or specialist in the circumstances[11].
Negligence will likely be found when it is determined that a defendant's conduct has departed or deviated from the appropriate standard of care in the circumstances.

Negligence is determined by comparing the conduct of the defendant in the circumstances of the case with the conduct that would have been exhibited by a reasonable, competent physician with the same or similar experience, practicing at the time of the alleged malpractice.

Negligence in and of itself is not determinative of liability on the part of the defendant in the absence of the further element of causation. In other words, there can be no liability in the absence of causation, even if it has been determined that the defendant's conduct was negligent in the circumstances.

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[10] *Crawford (Litigation guardian of) v. Penney*, [2003] O.J. No. 89

[11] Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996) at 157

In order to establish the element of causation, the plaintiff must prove that the defendant's negligence caused or contributed to the plaintiff's injury.[12] Causation need not be proved as a scientific fact but rather on a preponderance of probabilities.[13]

The final element to be established in a medical malpractice action is the nature of the damage or injury suffered by the plaintiff and accordingly, the monetary sum, or damages, which should be awarded to the plaintiff as a result of the injuries sustained.

As indicated above, in shoulder dystocia cases, the injuries that may be sustained by an infant can range from relatively minor injuries that resolve over a period of time to catastrophic injuries with severe and prolonged consequences for the infant and his or her caregivers.

In *Crawford (Litigation guardian of) v. Penney*[14], a decision of Justice Power of the Ontario Superior Court of Justice, the Plaintiff, Melissa Crawford, born December 27, 1983, was stillborn after her shoulders became impacted in her mother's birth canal. Melissa was resuscitated after birth but as a result of oxygen deprivation, she sustained serious brain injuries rendering her totally dependant on her caregivers and in need of constant care.

After engaging in an in-depth analysis of the appropriate standard of care and the conduct of the Defendants, Drs. Penney and Healey, Justice Power determined that these Defendants were negligent in the care that they provided to Jeanette Crawford, Melissa's mother, in the pre- and perinatal stages. Justice Power found that the negligence of these defendants caused Melissa's

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12 *Snell v. Farrell*, [1990] 2 S.C.R. 311, 72 D.L.R. (4th) 289 (S.C.C.); *Athey v. Leonati* [1996] 3 S.C.R. 458

13 *Lawson v. Laferriere*, [1991] 1 S.C.R. 541 (S.C.C.); *Snell v. Farrell*, [1990] 2 S.C.R. 311, 72 D.L.R. (4th) 289 (S.C.C.)

14 *Crawford (Litigation guardian of) v. Penney*, [2003] O.J. No. 89

injuries and the devastating consequences arising therefrom.

Melissa was awarded non-pecuniary damages in the amount of $280,000 subject to an additional amount for inflation.[15] Justice Power determined that Melissa would never be gainfully employed and accordingly, he determined that she had sustained a complete loss of earning capacity. He awarded damages on the basis of an estimated annual income of $36,000.[16]

After reviewing testimony presented by experts for the Plaintiffs and experts for the Defendants on the issue of Melissa's life expectancy, Justice Power held that Melissa's life expectancy was 35 years from her upcoming birthday, or 54 years in total. Based upon the assumption that Melissa would have retired at age 60, Justice Power concluded that there were six lost years and assessed a 30 per cent deduction.[17]

A significant portion of the damages awarded to Melissa were damages for the cost of future care for Melissa for the remainder of her lifetime. Provision was made for twenty-four hour constant care/supervision from a registered nurse in the day time and a registered practical nurse at night, an award was made for renovating the family's home to accommodate Melissa's needs and an award was made for the specific pecuniary claims related to Melissa's medical and other needs.

Melissa's parents, who advanced *Family Law Act* claims, were awarded damages for their personal and financial sacrifices and, as a result of the severity of Melissa's condition, for the loss of care, guidance and companionship that they might have expected to receive from Melissa. Justice Power fixed damages for Mr. and Mrs. Crawford in the amount of $80,000.00 each.

Justice Powers also determined that Mrs. Crawford had sustained a loss of income as a result of her early retirement necessitated by Melissa's need for constant care. Justice Power awarded Mrs. Crawford $66,400 for her loss of income and $36,300 for diminution of her pension benefits

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[15] Based on the supreme court trilogy of cases, *Teno v Arnold* [1978] 2 S.C.R. 287, *Thornton v School District No. 57* [1978] 2 S.C.R. 267 and *Andrews v Grand & Toy* [1978] 2 S.C.R. 229, the maximum amount that a court may award for non-pecunairy damages is in the range of $280,000-$290,000. Melissa was therefore awarded the maximum amount.

[16] Justice Power arrived at this estimate by considering the earning capacity and intelligence level of Melissa's siblings and parents

[17] A "Lost Years" claim may be advanced where a plaintiff's normal life expectancy has been shortened because of an accident or injury. The "Lost Years" are determined by estimating the difference between a plaintiff's pre-accident life expectancy and his or her diminished life expectancy. A court may make an award to compensate a plaintiff for the loss of income or for the loss of earning capacity during these "Lost Years". In other words, the plaintiff is compensated for the loss of income that he or she would have earned between the date of his or her expected death and the date of his or her expected retirement. In Toneguzzo-Norvell v. Burnaby Hopsital (1994) 110, D.L.R. (4th) 489, the Supreme Court of Canada upheld a fifty percent deduction. Other cases have provided for different percentage deductions.

calculated at present value. A further award of $750,000 was made for "services provided" by Mr. and Mrs. Crawford who devoted extraordinary time to caring for Melissa's needs for 18 years.

It is apparent from the foregoing decision that, an improperly managed case of shoulder dystocia, where the resultant injury to the infant is catastrophic in nature, can have devastating consequences and, where negligence is found, could expose a defendant to a potential claim for millions of dollars.
It is therefore incumbent upon physicians and specialists to ensure that they adhere to the appropriate standard of care when dealing with cases of shoulder dystocia.

Some medical professionals may argue that shoulder dystocia is an obstetrical emergency which cannot generally be anticipated and that the conduct of the physician or obstetrician faced with shoulder dystocia should be evaluated accordingly. While it is clear that shoulder dystocia is regarded as an obstetrical emergency, it is not true that shoulder dystocia cannot always be anticipated.

4. The Management of Shoulder Dystocia

Care During Pregnancy

The "management" of shoulder dystocia can be divided into two distinct phases, the care provided during the pregnancy and the care provided during the delivery process.

Dr. Dan Farine, a staff perinatologist at Mount Sinai Hospital and a leading expert on obstetrical care, has provided a useful guideline to some of the factors in determining an antepartum diagnosis of possible shoulder dystocia.

In a paper entitled "Shoulder Dystocia", presented at The Canadian Institute's 7th Annual Reducing the Risk of Obstetric Malpractice conference, Dr. Farine lists the following risk factors:

1. Fetal Macrosomia - large baby with a birth weight of 4000g or over.
2. GDM - Gestational Diabetes Mellitus
3. Measurements of Biacromial Diameter v. Abdomen and Head
4. CT Diagnosis

Other risk factors identified in cases of shoulder dystocia include maternal obesity, maternal diabetes, short maternal stature, prior macrosomic infant or family history of fetal macrosomia, gestation over 40 weeks, contracted or flat pelvis, maternal weight increases of more than 35 lbs, history of similar or previous problems, eight years or more since the mother's last labour, previous labour dysfunction.[18]

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[18] See: Http://www.medical-malpractice.us.com/shoulder_dystocia.html

Although these factors and indicators are not always determinative of the incidence of shoulder dystocia, it is important to take cognisance of the fact that these risk factors exist. Accordingly, when a physician or obstetrician is faced with a pregnancy punctuated by all or some of the foregoing factors, steps must be taken to ensure that appropriate care is provided to the mother during the course of her pregnancy to reduce the risk of shoulder dystocia on delivery.
In *Crawford (Litigation guardian of) v. Penney*[19], the court found that certain information was known about shoulder dystocia in 1983 and about the risks that could give rise to a case of possible shoulder dystocia.

During her pregnancy, Mrs. Crawford presented with a number of risk factors associated with a possible case of shoulder dystocia. After a careful evaluation of the factual matrix and after considering the relevant legal principles, Justice Power concluded that Drs. Penney and Healey were negligent in the following respects:

(a) They were or should have been aware, in 1983, that shoulder dystocia was associated with macrosomia and that macrosomia was associated with maternal obesity, family history of large gestational age infants, and gestational diabetes or diabetes. In light of this knowledge, they failed to adopt an appropriate plan of treatment.

(b) In the face of various pregnancy risks, some of which were identified by Dr. Penney during his care of Mrs. Crawford, he failed to recognize his lack of skill and expertise in his care of Mrs. Crawford and Melissa and failed to refer Mrs. Crawford for expert opinion or care. [20]

(c) Dr. Penney and Dr. Healey did not make any inquiry into a possible explanation for the three day labour and the use of forceps in Mrs. Crawford's previous delivery of her first child.

(d) Dr. Penney and Dr. Healey failed to consider that a woman's ability to deliver a macrosomic infant without difficulty on a prior occasion did not dictate that she would be able to do so again.

(e) They failed to appreciate that the large discrepancy between the birth weights of Mrs. Crawford's first two children constituted a warning that Mrs. Crawford tended to have diabetes in pregnancy.

(f) Despite the fact that ultrasound technology existed in 1983 and

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[19] *Supra,* page 45

[20] In this regard, the court recognized that there may be a duty to refer in certain circumstances

despite the fact that Dr. Penney had used ultrasound technology on previous occasions, he did not make use of timely ultrasound technology in this case and should have. Ultrasound might have revealed the possibility of shoulder dystocia.

(g) Given the various risk factors that were present including, that Mrs. Crawford was obese given her short stature, she was forty years old, she had a history of family diabetes and the fetus that she was carrying was large, Dr. Penney was negligent in failing to test Mrs. Crawford for gestational diabetes by way of either a glucose challenge test or a glucose tolerance test especially between 24-28 weeks if pregnancy.

Failing to adopt an appropriate plan of treatment during pregnancy can have devastating consequences. Once risk factors have been identified, it is essential that the situation be carefully monitored and that appropriate steps be taken to reduce the possibility of shoulder dystocia.

A physician must ensure that, if he or she does not have the adequate experience to handle the case, the case should be referred to the appropriate expert. Further, if the physician's practice is in an area which has inappropriate facilities, the case should be referred elsewhere.

A defendant cannot rely on the plaintiff to make a decision to seek a second opinion or to seek alternative care facilities in the absence of full knowledge of the potential outcome of the complications on delivery when an infant presents with shoulder dystocia[21]. It is vital that, where risk factors have been identified, the possibility of complications arising from possible shoulder dystocia is clearly communicated with the mother so that she can exercise informed consent[22] as to the nature and locality of her continued care.

If the mother is provided with sufficient information, she may elect to proceed with a caesarean section in order to minimize the risk of possible shoulder dystocia.

Care During Delivery

Where possible risk factors have been identified, the careful evaluation and monitoring required during pregnancy should continue right up until delivery. Some of the warning signs suggestive of shoulder dystocia have been said to be, prolonged second stage of labour and recoil of the infant's head on the perineum or "turtle's sign".[23]

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[21] *Crawford (Litigation guardian of) v. Penney*, [2003] O.J. No. 89

[22] The principles of informed consent would dictate that a medical practitioner clearly discuss the risks and the potential outcome of shoulder dystocia. *Bauer (Litigation Guardian of) v. Seager* [2000] M.J. No. (Q.B.)

[23] Http://www.fpnotebook.com

Once a shoulder dystocia has been identified, the management of the shoulder dystocia by the attending physician or obstetrician is crucial and the standard of care provided during this period of high risk will be carefully evaluated.

In his paper “Shoulder Dystocia”, which is referred to above, Dr. Farine provides the following useful guide when faced with a case of shoulder dystocia:

MANAGEMENT AT DELIVERY:

1. RECOGNITION:

   BIG HEAD
   HEAD RETRACTION

2. MANAGEMENT

   A. CALL FOR HELP (OBSTETRICIAN, ANAESTHESIA)
   B. PROCEED TO DELIVERY WITH YOUR MANOEUVERS PLANNED AHEAD

3. STEPS IN MANAGING SHOULDER DYSTOCIA:

   1. McROBERT’S MANOEUVRE
   2. MODERATE SUPRA PUBIC PRESSURE - NEVER FUNDAL PRESSURE
   3. CORK SCREW MANOEUVRE
   4. DELIVERY OF THE POSTERIOR SHOULDER
   5. TURNING BABY’S HEAD TO OBLIQUE POSITION
   6. BILATERAL EPISIOTOMIES
   7. BREAKING THE CLAVICLES (OR EVEN THE HUMERUS)
   8. SYMPHYSIOTOMY
   9. ZAVANELLI MANOEUVRE

It must be said that, even if a physician or obstetrician adopts all of the appropriate steps and acts reasonably in the circumstances, the infant and the mother may, nevertheless sustain injury.

In light of a medical malpractice action however, the question to be determined is whether the defendant’s conduct deviated from the appropriate standard of care in the circumstances. If a court determines that a physician or obstetrician has complied with the appropriate standard of care, liability will not attach despite the consequences.

6. Avoiding Litigation

In an attempt to avoid litigation a physician or obstetrician should bear in mind the following:

1. He or she should keep abreast of recent developments in the care and management of shoulder dystocia;
2. He or she should ensure that his or her examinations of the mother during the pregnancy are thorough and appropriate and if any risk factors are identified, that suitable steps are taken to manage those factors including the transfer to a tertiary care facility or the scheduling of a caesarean section, if appropriate;
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3. He or she should ensure that the mother is fully informed of the risk factors so that she can make appropriate decisions with respect to her continued care;
4. He or she should ensure that outside help is sought, or an appropriate referral made, where the physician or obstetrician does not have the appropriate experience required or where the facilities in his or her practice area will not cater for an obstetrical emergency such as a shoulder dystocia;
5. If the physician or obstetrician decides to continue with care, he or she should ensure that an appropriate treatment plan is prepared in advance in case of an encounter with shoulder dystocia; and
6. If the physician or obstetrician is faced with a shoulder dystocia during delivery, he or she should ensure that the recognized steps, based upon updated medical developments, are put into place in a timely and effective manner.

5. Conclusion

The experience of giving birth is an exciting and miraculous event. The birth process has the potential to be extremely traumatic for mother and child if inappropriately managed.

It is therefore incumbent upon the practitioners who provide pre- and perinatal care and who facilitate the birth process, to ensure that they are fully informed of and comply with the standards of care expected of them in the circumstances.