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MALPRACTICE: CASE OF THE LITTLE BIRD WITH THE BROKEN WING

By Preston Douglas, Esq.

Medical malpractice cases often fit into repetitive patterns. Clients call with histories that we have heard before. Frequently, we can fill out a malpractice story when the clients get halfway through their account of events. They believe their stories are unique and express surprise when they hear they are not alone.

Sadly, one such pattern of frequent malpractice is a birth injury to the nerve center called the brachial plexus, which is known generally as an Erb's[1] palsy case. Since Erb's palsy is a serious birth injury, most often related to obstetrical malpractice, consideration of the common elements of these cases will be instructive.

Erb's palsy is a crippling injury of the upper and middle arm caused by damage to a nerve center located between the shoulder and neck: the nerve center is called the brachial plexus, and the generic name for these injuries is brachial plexus palsy. While brachial plexus palsy is commonly associated with birth trauma, adults may also sustain brachial plexus injuries from excessive forces to the head and neck. When the palsy affects the hand, it is called Klumpke's; when it is severe enough, it will cause drooping of the eyelid on the affected side, which is called Horner's syndrome. Because the nerves of the shoulder blade may be affected, children with Erb's will demonstrate a phenomenon called "winging" of the scapula — their shoulder blade will protrude prominently on the affected side.

Brachial plexus injury almost always occurs during birth when the infant's head emerges but the shoulders become wedged inside the mother's birth canal. This situation (called shoulder dystocia) is dangerous because as the baby's umbilical cord is compressed in the canal, the baby can't yet breathe on its own with its chest inside the mother. Thus, the half-born child is deprived of oxygen. Often the obstetrician will see a retraction of the head back towards the mother's vagina, a sign called "turtling" which tells the doctor that the baby's shoulders are preventing him or her from passing through the birth canal. The baby has to be born soon, or it will die. But excessive force on the head and neck cannot be used. If the head is used as a lever to free the shoulders, the brachial plexus will he stretched or pulled out of the spine, resulting in a crippled baby.

I. Erb palsy or Erb-Duchene paralysis is the correct nomenclature; the injury is, however, is commonly called, "Erb's Palsy."

When an obstetrician runs across a shoulder dystocia, he / she has to be ready for the emergency. There is a prescribed set of maneuvers for freeing the shoulders with little risk of injuring the mother or her baby. For years now, the authoritative text for obstetrics has been *Williams Obstetrics*. Sadly, *Williams* has succumbed to the pressures of "politics," and has softened its didactics, so that its list of maneuvers for shoulder dystocia is couched in terms of suggestions, rather than mandates.

One of the first things an obstetrician should do is cut a generous episiotomy. The episiotomy is a scissors incision at the base of the vagina, to allow more room for delivery and it incidentally reduces the probability of a tear of the tissues in that region. Cuts are much easier to repair than tears, and episiotomies are elective procedures in many deliveries, at the discretion of the obstetrician. However, they are not elective in the case of shoulder dystocia. They are mandatory. When a shoulder dystocia results in Erb's palsy, the failure to do an episiotomy is almost enough, by itself, to he the cornerstone of a malpractice case.

With this background, let's consider three recent cases in which there was no episiotomy. All three babies, who happened to be girls, had varying severity of injury, ranging from general weakness to severe contracture of the elbow and hand. All of the children showed atrophy of the arm as they grew out of infancy and all had some winging of the scapula.

While an expert obstetrician in these three cases was willing to say that failure to cut an episiotomy was the direct cause of the injury, we felt that it was better to have additional malpractice; *Williams* says, "Some have advocated performing a large episiotomy..." (19th Edition, p. 511). It is unfortunate that a teaching text should have such equivocal language as this, but it means to the plaintiff's lawyer that a simple failure to cut an episiotomy is not enough to assure a liability verdict. Indeed, at deposition, the delivering physicians in all three cases took the position that an episiotomy was not mandatory in face of a shoulder dystocia; they all claimed it was an elective procedure.

All of this begs the real issue. It is likely that Erb's palsy is really due to excessive force applied by the obstetrician, in inappropriate directions to the head and neck in the attempt to free the stuck shoulders. Of course, with enough force, the shoulders will come free, at the price of a destroyed brachial plexus. The problem, then, is one of proof. How do you prove that the amount of force applied is excessive, and it exceeds the safe limits of professional judgment?

Recently, we took in a new Erb's where, although we don't have the records yet, we know we can prove excessive force. As it turns out, the aunt of the baby was in the delivery room with a video camera. When we played back this extraordinary tape, we could see the obstetrician rising on her toes while applying strong downward traction to the baby's head. We can't wait to see the hospital records. Here, we will not need to prove a failure to follow the prescribed maneuvers in freeing a shoulder dystocia.

Normally, however, it will take something more than a bare allegation of excessive force, because the injury itself is not proof, *per se*, of the deviation from an

give rise to the inference that excessive force was used, because the necessary amount of force is normally within the judgment of the delivering physician:

> A doctor is not liable for an error in judgment if (he, she) does what (he, she) decides is best after careful examination if it is a judgment that a reasonably prudent doctor could have made under the circumstances. (PJI 2:150)

If more is needed to close the liability case, then it will have to be found during prenatal care, or elsewhere in the delivery. Take into account, however, that it is generally conceded not possible to accurately predict shoulder dystocias in advance; otherwise, all such babies would be delivered by caesarean. There are, however, predisposing factors that ought to warn the obstetrician. Obesity, diabetes, and post-datism (babies who are overdue) have much higher incidences of shoulder dystocia. In appropriate cases, efforts should be made to demonstrate that the doctor had premonitory warning.

The real heart of the case will lie in the comparison of the labor and delivery notes, plus the defendant's testimony, against the prescribed standard maneuvers advocated by *Williams.* Indeed, *Williams* has a list of these maneuvers and suggests that they be incorporated into a "drill" for these emergencies. The list is long, and any attorney who expects to be effective in trying these complex cases should study it in the textbook. We will consider a few.

The first line of defense against shoulder dystocia in modern obstetrics is a benign maneuver, called McRobert's. In McRobert's, the mother's legs are held by two assistants, often a nurse and the patient's husband. The legs are brought into and over the mother's body, so that her feet are somewhere over her head (depending on her flexibility). The theory is that this change in the leg position changes the relative position of the baby's shoulders and the mother's pelvis, allowing it to slip by the obstruction. Apparently, this simple change in position frees the majority of dystocias, without any undue force or injury to the child. Did the obstetrician do a McRobert's? No? And if he did try a McRobert's did he do it without previously cutting an episiotomy? That's not good practice either.

Next, consider the nurse's assistance. Applying pressure to the upper part of the womb, which is called fundal pressure, may assist ordinary delivery. But fundal pressure is contraindicated when there is a shoulder dystocia. All it does is push the jammed shoulders into the obstruction, which will tend to injure the brachial plexus, and that is clearly undesirable. On the other hand, pressure over the mother's pubic bone, where the shoulders are stuck, can push the upper shoulder under the bone, freeing that shoulder to pass through the canal.

A more recent victim of Erb's was a second baby, born two years following the birth of a boy who weighed ten pounds, who also had Erb's palsy. Although the mother had private prenatal care, no one in her doctors' group thought to review a history of the first pregnancy. The second baby again weighed over ten pounds, and this time the baby girl sustained a severe brachial plexus injury. The doctors were "surprised" by the size of the girl, despite having to induce labor after the 42nd week, and a prolonged second stage of labor.

If McRobert's fails to free a shoulder dystocia, the next maneuver in the "drill" is the Wood's corkscrew. Wood's requires the obstetrician to slide his hand into the vagina along the baby's back to attempt to turn the shoulders into a more favorable diagonal to allow passage. In one of last year's cases, the delivering doctor did not have the requisite training to deal with a shoulder dystocia, and when he came to his deposition, he still hadn't done his homework. His testimony described an attempted Wood's maneuver with one hand on each side of the shoulder.

alongside a full-term baby.

In that same case, there was a rare reference to the Zavenelli maneuver in the hospital record. Zavenelli has been discussed in the medical journals for about 15 years and has found its way into *Williams Obstetrics*. But it remains a tactic of last resort. The baby in our case was actually delivered easily by a proper Woods, performed by an attending obstetrician who answered the hapless first doctor's call for help. (Incidentally, *Williams* actually says that one of the first things an obstetrician should do when faced with a shoulder dystocia is to call for help!) In this case, they were preparing to perform a Zavanelli when the attending came along and "easily freed the shoulders with a Wood's corkscrew."

What is a Zavenelli? When all else fails, an attempt is made to push the baby's head back inside the birth canal, and delivery by caesarean is accomplished from above. Forcing a baby's head back into the canal is a nightmare of risks, which explains why Zavenelli is so rarely attempted.

Before reaching the level of desperation that would create the need for a Zavenelli maneuver, there are less dangerous steps left in the dystocia drill. If Wood's fails, one arm may be grasped and swept across the baby, narrowing the shoulders in a manner akin to the way we pull ourselves in when we try to squeeze into a tight subway seat. Although this may cause clavicle fracture, this intentional injury is acceptable because the collar bone will heal while Erb's palsy may be permanent and devastating. In the Zavanelli case above, the defendant never tried any of these additional steps; he probably didn't know them.

The current *Williams* section on shoulder dystocia should be studied before depositions are started. Such a review is a good idea periodically, as the state of the art does certainly change. The litigation of an Erb's case requires a planned approach, so that the bill of particulars, depositions, and CPLR §3101 (d) expert discovery should track each other; the theories do have to coincide by the time of the trial.

Consider the following negligence paragraph from the bill of particulars in one of the cases above. Notice that the bill was custom-drafted for that particular case. Don't assume that it can be copied verbatim for any Erb's case. It is presented as an example of the draftsmanship that goes into an Erb's case, from its very early stages. The paragraph follows:

> The negligence, carelessness and malpractice of defendant XXX MEDICAL CENTER, its agents, servants and/or employees, consisted of failing to promptly advise the obstetrician of the impending macrosomic delivery, and in thereby forcing a vaginal delivery; in using labor enhancing drugs; in failing to accurately estimate the size of the baby; failing to perform an atraumatic delivery; forcing delivery; forcing vaginal delivery; failing to use appropriate delivery maneuvers; failing to perform a Wood's maneuver; failing to perform a McRobert's maneuver; failing to deliver the anterior shoulder; failing to deliver the posterior shoulder; failing to perform a sweeping maneuver; failure to intentionally fracture the clavicle; failure to do an episiotomy; in failing to note, record and act on shoulder dystocia; in using inappropriate direction; in pulling on the head; in failing to perform a caesarean section; failing to chart and heed a Friedman's curve; and in failing to diagnose and treat appropriately a large-for-gestational-age fetus.

Here now is a typical injury paragraph in one of these cases. This too must be tailored for the case. Does your child client have Homer's syndrome? Is there upper and lower palsy (Erb's and Klumpke's)?

> Erb's palsy; Klumpke's palsy, Homer's syndrome, brachial plexus trauma; avulsion, stretching, and mechanical destruction resulting in paralysis, winging of the scapula, atrophy of the musculature of the left arm, growth differential between left and right side requiring intensive long-term therapy and potential future surgery.
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> All of the foregoing are permanent in nature and not subject to cure; all with attendant pain, suffering, long-term social embarrassment and physical handicap.

While it will be up to your expert to classify the severity of the injury our own unofficial criterion can be used for determining the severity of an Erb's palsy. Once the child is old enough to follow simple commands, we ask him/her to cover their ears with their hands. A *mildly* injured child will comply, each hand going to an ear, with perhaps some awkwardness on the weak side. A more *moderately* injured child will lift the weak hand above the shoulder with the "good" hand, and then cover the strong side once the weak hand is in place. A severely injured child will carry the weak hand at his / her waist, with fingers curled (contracted) and there will be a difference in size between the two hands, even at the age of two or three.

Erb's palsy is a tragedy. That it occurs as frequently as it does is particularly distressing. There should be further recognition in medical obstetrics that the lessons are not being learned, to the permanent detriment of these handicapped children. Nevertheless, we must recognize one positive comfort in these youngsters. Perhaps as a consequence of the need to compensate for their handicaps, these kids often thrive. They do well in school; they go to college; and, finally, they often give their parents reason to be proud.