



## KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION ETHICS AND MEDICOLEGAL COMMITTEE

# MEDICOLEGAL BULLETIN

Week 25: Birth Injury & Shoulder Dystocia – When Does an Unavoidable Obstetric Emergency Become a Negligence Claim?

### 1. REAL LIFE CASE SCENARIO

A 30-year-old multiparous woman with gestational diabetes presented in spontaneous labour at term. Labour progressed normally, and the fetal head delivered vaginally. Suddenly, the shoulders failed to deliver with routine gentle traction. Shoulder dystocia was recognized, additional assistance was called, and appropriate maneuvers were performed. The baby was delivered but subsequently diagnosed with a brachial plexus injury. The parents alleged that excessive force had been applied and that cesarean section should have been performed beforehand. The obstetrician maintained that shoulder dystocia was an unpredictable emergency and appropriate maneuvers had been used. The central medicolegal question Does neonatal injury after shoulder dystocia automatically mean negligent delivery? The occurrence of an injury alone does not establish negligence. The clinical response and documentation becomes crucial.

### 2. MEDICOLEGAL RISKS IN SUCH CASES

Shoulder dystocia is vulnerable to litigation because delivery may appear normal until the emergency suddenly occurs. Adverse outcomes include:

- Brachial plexus injury
- Clavicular or humeral fracture
- Hypoxic-ischemic injury
- Neonatal resuscitation or NICU admission

Common allegations: excessive traction, failure to recognize promptly, incorrect maneuver sequence, delay in calling assistance, failure to anticipate macrosomia, failure to offer cesarean, inadequate documentation.

### 3. WHAT THE LAW EXPECTS

The law does not expect an obstetrician to prevent every shoulder dystocia. Prediction is imperfect. What is expected is a reasonable and timely response according to accepted obstetric practice. Once shoulder dystocia is recognized:

- Call for additional help immediately.
- Avoid excessive downward or lateral traction.
- Arrange neonatal support.
- Document the sequence accurately afterward

Note the time of head delivery  
Perform accepted maneuvers systematically  
Escalate if initial maneuvers fail

The legal question is usually: “What did the obstetric team do once shoulder dystocia occurred?” — not why it occurred.

### 4. DOCUMENTATION – THE DOCTOR’S STRONGEST DEFENSE

- Time of head delivery & dystocia recognition.
- Sequence of maneuvers performed.
- Time of complete delivery & head-to-body interval.
- Condition of newborn at birth & Apgar scores.
- Cord blood gases if obtained.
- Neonatal examination findings.

Personnel called for assistance  
Maternal position & episiotomy if performed  
Birth weight  
Resuscitation required  
Maternal trauma noted  
Counseling of parents documented

Avoid simply writing “Shoulder dystocia managed.” That tells a future reviewer almost nothing. Write the actual sequence of maneuvers while events are fresh.



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### **5. PRACTICAL SAFE PRACTICE – WHAT TO DO**

- Identify antenatal risk factors without assuming dystocia can always be predicted
- Ensure labour-room staff know the shoulder dystocia protocol
- Call for help immediately and clearly announce: “Shoulder dystocia”
- Assign someone to record timings and maneuvers
- Avoid fundal pressure and excessive traction on the fetal head
- Follow accepted maneuvers systematically
- Ensure neonatal assessment after delivery
- Explain the event honestly to the parents
- Complete detailed documentation immediately after stabilization

Regular simulation drills are particularly valuable because shoulder dystocia requires coordinated action within minutes.

### **6. COMMON MISTAKES TO AVOID**

- Panicking and applying excessive traction
- Applying fundal pressure
- Repeatedly performing the same ineffective maneuver
- Failure to call for help promptly
- Poor communication among the delivery team
- No neonatal examination for birth injury
- Writing only a one-line delivery note
- Altering the record after an injury is diagnosed

One of the worst medicolegal mistakes is trying to reconstruct the exact sequence several days later. Document while events are fresh.

### **7. CLINICAL–LEGAL PEARL**

Shoulder dystocia may be unpredictable. Your response to it should not be.

A trained team, systematic maneuvers, and contemporaneous documentation are the obstetrician’s strongest protection.

### **8. REAL COURT CASE INSIGHTS (FOR UNDERSTANDING)**

The presence of a neonatal injury does not by itself establish negligence. Assessment generally focuses on:

- Were antenatal risk factors appropriately considered?
- Was vaginal delivery a reasonable decision?
- Was shoulder dystocia recognized promptly?
- Were accepted maneuvers performed?
- Was inappropriate force used?
- Was neonatal support available?
- Does the delivery record support the doctor’s account?

Months or years later, nobody reliably remembers whether McRoberts maneuver preceded suprapubic pressure or how rapidly help arrived. The case sheet remembers – if the team documented it properly.

### **9. TAKE-HOME MESSAGE**

A poor neonatal outcome does not automatically mean negligent obstetric care. Medicolegal protection comes from:

Preparation → Recognition → Call for help → Systematic maneuvers → Avoid excessive traction →

Neonatal assessment → Honest communication → Detailed documentation.

Do not improvise under PRESSURE.

Train before the EMERGENCY occurs.

***Next Week’s Topic; Ovarian Mass Surgery in a Young Woman –  
Unexpected Oophorectomy, Loss of Fertility, and Medicolegal Liability***



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