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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

Larry Hyman, Circuit Court Judge

Appellate Case No. 2019-001304

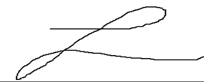
Phillippa Smalling, individually and as Next Friend for Jahmerican M., a minor — Appellant,

v.

Lisa R. Maselli, M.D., both individually and as agent/employee of Carolina OB-GYN, — Respondents.

PETITION FOR REHEARING

GRAHAM LAW FIRM, P.A.



Edward L. Graham (SC Bar: 2483)
122 Donald Dr.
Pendleton, SC 29670
Telephone: 864-527-0411
Email:
egraham@grahamlawfirm.net
GRAHAM LAW FIRM, P.A.
Attorneys for Appellant

November 17, 2022

INTRODUCTION

Petitioner hereby petitions this Court for reconsideration of its Opinion No. 5949, filed on November 2, 2022. Resolution of this appeal centers on the proper statutory construction of S.C. Code Ann. § 15-32-230 ("Medical and Obstetrical Emergency Statute" or "this statute"). If this statute applies, a medical malpractice plaintiff cannot prevail absent proof of gross negligence. If this statute does not apply, proof of ordinarily negligence will suffice to establish liability. This statute reads as follows:

> Emergency medical and obstetrical care exceptions.
>
> (A) In an action involving a medical malpractice claim arising out of care rendered in a genuine emergency situation involving an immediate threat of death or serious bodily injury to the patient receiving care in an emergency department or in an obstetrical or surgical suite, no physician may be held liable unless it is proven that the physician was grossly negligent.
>
> (B) In an action involving a medical malpractice claim arising out of obstetrical care rendered by a physician on an emergency basis when there is no previous doctor/patient relationship between the physician or a member of his practice with a patient or the patient has not received prenatal care, such physician is not liable unless it is proven such physician is grossly negligent.
>
> (C) The limitation on physician liability established by subsections (A) and (B) shall only apply if the patient is not medically stable and:
>
> (1) in immediate threat of death; or
>
> (2) in immediate threat of serious bodily injury.
>
> Further, the limitation on physician liability established by subsections (A) and (B) shall only apply to care rendered prior to the patient's discharge from the emergency department or obstetrical or surgical suite.
>
> S.C. Code Ann. § 15-32-230

ARGUMENT

I. The Court Overlooked and/or Misapprehended that Because This Statute is Ambiguous and in Derogation of Common Law, Its Conditions and Qualifiers Must Be Liberally Construed to Minimize Its Departure from the Common Law.

a. Subsections (A) and (B) of the Medical and Obstetrical Emergency Statute Are Ambiguous.

Key phrases in Section (A) are undefined in the statute and in dictionaries, including specialized medical dictionaries. These include conditions and qualifiers such as "genuine emergency situation," "immediate threat," and "the patient is not medically stable," among others.

This statute is unclear whether "genuine emergency" has a smaller scope than "emergency" and/or the phrase, "emergency basis," the latter being used in Subsection (B). It is similarly unclear whether "immediate" means "now," "without delay," or "soon," as in "imminent."

Most pertinent to this Petition is how one should interpret the phrase from Subsection (C), "The limitation on physician liability established by subsections (A) and (B) shall only apply if the patient is not medically stable…." Further ambiguity arises from whether all subsections should be construed together or separately; and what differences in statutory construction, if any, would follow.

"If the statute is ambiguous…Courts must construe the terms of the statute." *Town* of *Mt. Pleasant v. Roberts,* 393 S.C. 332, 713 S.E. 2d 278 (2011). The statutory language must be construed considering the intended purpose of the statute. Id. A court must not construe a statute in a way that leads to an absurd result or renders it meaningless. *Lancaster Cnty Bar Ass'n v. S.C. Comm'n on Indigent Def.,* 380 S.C. 219, 670 S.E. 2d 371 (2008). ("In construing a statute, this

Court will reject an interpretation when such an interpretation leads to an absurd result that could not have been intended by the legislature".) These are well-established rules of statutory construction. See *Ranucci v. Crain,* 409 S.C. 493, 763 S.E.2d 189 (2014).

b. This Statute Must Be Strictly Construed Because it is in Derogation of Common Law

In creating tort immunity which did not exist under the common law, S.C. Code Ann. § 15-32-230 plainly abrogated common law tort principles. "[S]tatutes in derogation of the common law are to be strictly construed." *Grier v. AMISUB of S.C., Inc.*, *supra,* citing *Epstein v. Coastal Timber Co.*, 393 S.C. 276, 285, 711 S.E.2d 912, 917 (2011). Additionally, "[u]nder this rule, a statute restricting the common law will 'not be extended beyond the clear intent of the legislature.'" *Id.* citing *Crosby v. Glasscock Trucking Co.*, 340 S.C. 626, 628, 532 S.E.2d 856, 857 (2000).

All subsections of this statute must be strictly construed in a manner that disturbs long-standing common law only to the extent necessary to effectuate the clear intent of the legislature. *See also Velazquez v. Jiminez,* 172 N.J. 240, 257, 798 A.2d 51, 62, (N.J. 2002) (noting courts give "'narrow range' to statutes granting immunity from tort liability because they leave 'unredressed injury and loss resulting from wrongful conduct.'").

Every word and phrase must be construed to depart as little as possible from the common law. See, *In re Decker*, 322 S.C. 215, 219. 471 S.E.2d 462, 463 (1995) ("A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous….," citing 82 C.J.S. Statutes, Section 346.)

In its enactment of the Medical and Obstetrical Emergency Statute, the General Assembly chose to include several conditions and qualifiers on its grant of immunity from tort claims based

on ordinary physician negligence in an emergency. Respondents have the burden of proof that they have met these conditions. These qualifiers must be given effect as requiring proof beyond that which inheres within the concept of an emergency, or they would be surplusage with no purpose.

The only condition or qualifier this Argument addresses substantively is the General Assembly's directive that statutory immunity "***shall only apply if the patient is not medically stable***." (Emphasis added.) By this phrasing the General Assembly made explicit its intent that statutory immunity is conditioned in part on whether the emergency involves medically stable patients or those who are "not medically stable." This distinction is important because if the patient is medically stable, physician accountability for ordinary negligence in an emergency is preserved, which would otherwise require proof of gross negligence[1].

To construe the Medical and Obstetrical Emergency Statute properly, to depart as little as possible from the common law, its conditions and qualifiers must not be read out of the statute. *Ballard v. Ballard*, 314 S.C. 40, 443 S.E.2d 802 (1994). To do otherwise would be error. These conditions must instead be applied rigidly and liberally to respect and effectuate legislative intent.

In the present case, "***the patient***" refers to Plaintiff and/or her son. Under strict statutory construction, "t***he patient is not medically stable***" can only refer to the actual contemporaneous medical instability of "the patient." (Emphasis added.)

This last point is critically important for proper construction of this statute. Because strict construction requires the least possible departure from common law, one cannot create a jury question whether "the patient is not medically stable" by eliciting testimony (1) that shoulder

[1] There are other conditions and qualifiers which, if not met, would disallow immunity, but that is beyond the scope of this Argument.

dystocia is an unstable situation; (2) that shoulder dystocia presents risks or threats of potential harm; or (3) that the obstetrician did not know whether the baby was stable. The Medical and Obstetrical Emergency Statute considers actual, contemporaneous medically unstable patients, not unstable situations, risks, potential harm, and the like. Such testimony is probative of shoulder dystocia being an obstetrical emergency. However, to allow an inference from such testimony that babies in unstable situations are therefore "not medically stable" invites impermissible speculation and offends legislative intent.

c. One May Not Properly Infer that a Shoulder Dystocia Patient is Not Medically Stable Because Shoulder Dystocia is an Unstable Situation.

The seriousness of each shoulder dystocia varies. Some shoulder dystocias should be easy to resolve and substantially risk-free, especially when the fetal heart monitoring is reassuring right before shoulder dystocia and the baby delivers within a few minutes. An example is the sixty second dystocia in the present case. These almost always involve patients who were actually and contemporaneously stable throughout the emergency, and surely when Apgar scores and cord blood gases following delivery are excellent. For such a patient to be injured, medical negligence would most likely have caused the injury, despite the baby's medical stability. In such cases tort liability should follow from proof of ordinary negligence.

Other shoulder dystocia emergencies may be quite challenging to resolve and bear significant risks of harm, especially if the umbilical cord is completely cut off and the baby remains stuck for more than five minutes. These patients most likely are "not medically stable," at least during the latter stages of the emergency. Apgar scores and cord blood gases after delivery could provide the definitive answer. If a tort claim is brought following injury in this context, liability

would be determined under the gross liability standard, assuming all other statutory conditions are met.

Respondents' experts testified that shoulder dystocia is an unstable situation; and this child was "not medically stable" because her birth was complicated by shoulder dystocia. Unquestionably, a shoulder dystocia emergency embodies an "unstable situation." As an obstetric emergency, it necessarily involves an unstable situation, or it would not be an emergency. However, this provides no information about medical stability of an individual patient.

The same reasoning applies to all medical emergencies. An "unstable situation" inheres within the concept of the emergency. In the face of an unstable situation, some patients will be medically stable, and others will not. The General Assembly recognized this fact when it chose to grant immunity to the physician whose patient was not medically stable, but not for the physician whose patient was medically stable. That an emergency presents an unstable situation says nothing about whether a given patient is medically stable in the face of the unstable situation. Without an unstable situation, there is no emergency. With an unstable situation, some patients will be medically stable, and others will not.

The Court's Decision endorses the concept that proof of an "unstable situation," characteristic of every emergency, permits an inference that an emergency patient is "not medically stable." This is error because it impermissibly reads the "patient is not medically stable" qualifier out of the statute. See, *In re Decker*, *supra*, *Ballard v Ballard, supra*. It disregards the legislature's deliberate distinction between medically stable patients and those "not medically stable."

The General Assembly expressed their clear intent for this statute to distinguish between those who are medically stable despite the emergency and those who are not. As applied to this case, legislative intent distinguishes (1) one in excellent, medically stable health before and after a sixty second shoulder dystocia; and (2) those medically unstable before, during and after an emergency.

The legislature surely did not intend for the Court to lump all emergency patients automatically into the "not medically stable" category, on the basis that all are in an unstable situation. It is error for the Court to allow such broad, non-patient-specific testimony, and jury inferences therefrom, to undermine material legislative distinctions.

Legislative intent mandates that this statute be construed to distinguish meaningfully between emergencies involving stable patients from those "not medically stable." If there is direct evidence of the actual, contemporaneous stability or instability of the patient **during the emergency**, this would be controlling, at least in most situations, because such evidence focuses on "the patient," not the situation. In some emergencies, like shoulder dystocia, there will be no such direct evidence.

In such situations, Appellant suggests the reasonable way for the Court to resolve the "not medically stable" issue is to examine direct evidence of the patient's medical stability before and after the emergency. Instability before would be strong evidence of a "not medical stable" patient, as would instability afterwards. Medical stability before and after are compelling proof that the patient was actually and contemporaneously stable during the medical emergency. In this case Respondents' experts conceded that "the patient" was "medically stable" right before and after the emergency. These concessions by the Respondents own experts are telling. With no direct evidence to the contrary, the Court should rule that "the patient" was actually and

contemporaneously "medically stable" as a matter of law. The Court should not allow speculative inferences arising from an emergency itself to eviscerate legislative distinctions. Considering statutory language, legislative intent, strict construction, and concessions by Respondents, the trial court should have deemed Appellant's son to be medically stable as a matter of law. Respectfully, it was error for this Court not to reverse the trial court on this issue.

Speculation by Respondents' experts boils down to this: We admit the baby had reassuring fetal heart monitoring and medical stability through the moment the shoulder dystocia started; and we admit the baby had excellent Apgar scores, cord blood gases, and medical stability when born sixty seconds later. However, because shoulder dystocia is an obstetric emergency, this was an unstable situation like all medical emergencies. Because it was an unstable situation, the baby's medical stability before the shoulder dystocia may have been transformed suddenly into medical instability for sixty seconds, then suddenly recovered his medical stability.

To give any weight or legal credence to such testimony creates the unacceptable risk that a medically stable shoulder dystocia patient will be deemed not medically stable based on unfounded conjecture and speculation. This is contrary to deliberate legislative distinctions. The mere presence of shoulder dystocia is not probative of any individual patient being actually and contemporaneously "not medically stable." Testimony that shoulder dystocia is an "unstable ***situation***" is just another way of saying shoulder dystocia, an obstetric emergency, was present. Unwarranted inferences from wordplay like this deserve no legal effect.

Testimony of an unstable situation glosses over whether an individual emergency patient was medically stable or not. Most are. Some are not. Considering the legislative distinctions, strictly construed, it is illogical to permit factors inherent in the definition of emergency to

recharacterize otherwise stable patients as "not medically stable." To do so would eviscerate the statutory distinction between stable and "not medically stable" patients. Stated differently, all emergency patients would be "not medically stable" if the same factors which establish an emergency are deemed to establish a "not medically stable" patient.

If the General Assembly had intended its "the patient is not medically stable" qualifier to be met by broader evidence that a shoulder dystocia patient is in an unstable situation, at risk or threat of potential harm, it could have easily said so. Doing so would have been as easy as saying immediate "threat" of harm, as it did in another part of the statute. That it did not speaks volumes. Instead, the legislature chose to use the more restrictive phrase, "the patient is not medically stable." "[T]he patient," not the situation.

This was intentional. It makes sense. All true emergencies entail ***unstable situations*** and ***risks*** or ***threats*** of ***potential*** harm. With no ***risk*** or ***threat*** of harm there is no true emergency. With no unstable ***situation***, no true emergency can exist.

The sole purpose of statutory conditions and qualifiers is to ***limit*** application of a statute, not to match it. In the present case, conditions and qualifiers of the Medical and Obstetrical Emergency Statute exist to allow the application of this statute to fewer than all emergencies. Such conditions and qualifiers would be meaningless if the Court allows testimony of an unstable situation to serve as *prima facie* evidence of a not medically stable patient. factors necessary to meet the definition of an emergency were deemed sufficient to meet the statutory conditions and qualifiers, the conditions and qualifiers would be meaningless and superfluous. This would make legislative enactment of these qualifiers and conditions an exercise in futility. This would be an absurd result.

Strict construction of the Medical Emergency Statute requires that "the patient" in the present case be limited to Plaintiff and her son. It requires "the patient is not medically stable" qualifier to focus solely on the specific patient(s)' actual contemporaneous stability or instability during the shoulder dystocia emergency. Strict construction requires that no legal effect be given to testimony about unstable situations, threats or risks of harm, except to the extent it serves as evidence of an emergency. Appellant's son was medically stable as a matter of law, and inferences or rulings to the contrary are erroneous.

II. The Court Overlooked and/or Misapprehended That This Appeal Involves Statutory Construction, and Appellant Seeks a Ruling that Respondents' Evidence Does Not Create a Jury Issue When the Statute is Properly Construed.

This appeal presents issues of statutory construction, legal issues for the Court. The Court seemingly focused more on whether conflicting expert testimony was presented than on statutory construction.

This Court held that Respondents' testimony of an unstable situation created a jury

question of whether the patient was not medically stable. This was error, for reasons expressed *supra*. The mandate of strict construction principles requires narrow interpretation of immunity statutes. The corresponding mandate of strict construction principles requires rigid, liberal interpretation of exceptions to immunity statutes.

By disregarding these considerations, the trial court erred in denying Appellant's motion for directed verdict and her related post-trial motions. Respectfully, this Court erred in not reversing the trial judge.

The issue for the Court is not whether opposing experts presented conflicting testimony, as experts do, and as these experts obviously did. The testimony of the defense experts

unquestionably created a jury issue about presence of an obstetric emergency. But that testimony is inapposite.

The legal challenge for the Court is two-fold: (1) interpret the statute using strict construction principles; then (2) based on this construction, evaluate whether Respondents' evidence of an unstable situation, threats and risks of potential harm was sufficient to create a jury question whether "the patient was not medically stable." Ruling that it was insufficient is supported by the fetal heart monitor strips, the Apgar scores, cord blood gases, and a strict but harmonious construction of the statute. It respects the General Assembly by upholding its decision to distinguish medically stable from "not medically stable" emergency patients in applying this tort immunity statute.

All emergency patients are in unstable situations. All face threats and risks of potential harm. However, when the Medical and Obstetrical Emergency Statute is properly construed, evidence of unstable situations, threats and risks of potential harm do not reach the material issue; i.e., whether the patient was ***actually*** and ***contemporaneously*** "not medically stable" during ***this*** shoulder dystocia. With all evidence ***on point*** confirming the medical stability of Plaintiff and her son at all relevant times, no jury issue was created on this subject.

III. The Court Overlooked and/or Misapprehended that Facts Not Known Until After Delivery Are Properly Used to Determine if a Patient was Medically Stable During a Shoulder Dystocia.

It is axiomatic that facts not known until after birth cannot be used to prove negligence during birth. This makes sense. A physician's conduct is to be evaluated based on the same or similar circumstances at the time of the alleged negligence. Fact not knowable until later are not relevant to physician conduct before. Therefore, it is correct to give a charge on hindsight directing the jury to disregard such evidence in evaluating whether a defendant physician was negligent.

Using evidence of post-birth medical stability is different. Its relevance is not about a physician's decisions and actions during the shoulder dystocia, but whether the patient was actually and contemporaneously "not medically stable" during the shoulder dystocia.

Although the hindsight rule rightly precludes use of after-discovered facts to prove negligence, there is no sound reason to preclude its use to prove whether a baby was medically stable during the shoulder dystocia. Post-birth evidence is probative of the baby's stability or instability during the shoulder dystocia but has no relevance to physician negligence. To allow it is supported by statutory language, strict construction, logic, common sense and concessions by Respondents. Respondents have cited no authority that would preclude the use of such evidence for this purpose.

Ironically, Respondents in their briefing and the Court in its Decision quoted testimony from Respondents' experts that the baby's healthy oxygen status after birth proved what a fine job Dr. Maselli had done. Though this testimony represents flawed reasoning, it is interesting that Respondents called such post-birth testimony to the Court's attention, while arguing that post-birth facts are irrelevant, and a hindsight charge was proper.

The trial judge should not have given this charge. There is no S.C. law justifying the charge in the context of this case.

The charge was prejudicial to Plaintiff. It directed the jury to disregard probative evidence about whether the patient was "not medically stable," a pivotal issue in the case. Jury resolution of the medical stability issue determined whether Appellant had to prove ordinary negligence or gross negligence to prevail. They found no gross negligence. But for the improper charge, there is a strong possibility the jury may not have reached the gross negligence issue in their deliberations.

CONCLUSION

For the reasons stated, Appellant requests the Court to grant a rehearing of all issues. Alternatively, Appellant requests the Court to modify its Decision in accord with this Petition, thereby: (1) reversing the Trial Court's order denying Appellant's post-trial motions; and (2) remanding for a new trial with the Medical and Obstetrical Emergency Statute ruled inapplicable as the law of the case.

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PROOF OF SERVICE

I hereby certify that one copy of the ***Petition for Rehearing*** in the above-referenced matter was served by e-mail following the same being emailed to the Court's e-filing e-mail address.

James B. Hood
John O. Radeck, Jr.
Hood Law Firm, LLC
Post Office Box 1508
Charleston, SC 29402

GRAHAM LAW FIRM, P.A.

Edward L. Graham (SC Bar: 2483)
GRAHAM LAW FIRM, P.A.
120 Donald Drive
Pendleton, SC 29670
egraham@grahamlawfirm.net
843-496-4996 (t)
Attorneys for Appellant

Eugene Benton

From: Eugene Benton
Sent: Thursday, November 17, 2022 11:39 PM
To: Julie Dunn; Allen, Claire
Cc: Info; Deborah Sheffield; Kitchings, Jenny; Edward Graham; Jamie Hood; John Radeck; dhsheffieldatty@aol.com
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Eugene B. Benton
Graham Law Firm, PA
5042 Poole Street
North Charleston, SC 29405
(843) 489 – 7756 cell
1-800-859-7028 (fax)