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May 30 2023

S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In the Supreme Court

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APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

Larry Hyman, Circuit Court Judge

Appellate Case No. 2019-001304

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

v.

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

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# AMENDED PETITION FOR WRIT OF CERTIORARI

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Pursuant to the South Carolina Appellate Court Rules, Petitioner Phillippa Smalling ("Petitioner" or "Mother"), individually and as Next Friend for Jahmerican M., a minor, ("Son" or "Child") hereby seeks a Writ of *Certiorari* to review the Court of Appeals' denial of Petitioner's appeal. This Court should grant the Writ, reverse the Court of Appeals, and grant a new trial in which the purported statutory defense under S.C. Ann. §15-32-230 is disallowed as a matter of law.

## INTRODUCTION

Central to this Petition is the proper statutory construction of S.C. Code Ann. § 15-32-230 (the "Statute") which, *inter alia*, codified major changes in the common law by providing physicians immunity from liability for injuries caused by their negligence in certain emergencies in certain locations. 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

## QUESTIONS PRESENTED FOR REVIEW

1. **Did the Could of Appeals Err in Not Strictly Construing the Statute, as it is Ambiguous, with Unclear Legislative Intent, and in Derogation of the Common Law?**

2. **Did the Court of Appeals Err in Not Properly Construing the Statute and in Not Ruling that "the Patient" Was "Medically Stable," as a Matter of Law?**

3. **Did the Court of Appeals Err in Not Ruling There Was Prejudicial Error in the Trial Judge's Giving a Hindsight Charge Without a Qualification that the Infant's Post-Birth Condition May Properly Be Considered on the Medical Stability Issue?**

## STATEMENT OF FACTS

This is an obstetrical malpractice case involving Phillippa Smalling and the birth of her son, Jahmerican M., on April 27, 2013. (R. pp. 71 -72). Lisa R. Maselli, M.D. ("OB") was the delivering obstetrician. During birth, Petitioner's Son sustained severe and permanent injuries to his brachial plexus nerves on the right side. Brachial plexus nerves provide motor function to the muscles in the arm and shoulder area, as well as certain sensory functions. (R. pp. 91-92).

During delivery, after the Son's head delivered, his top shoulder ("anterior" shoulder) did not deliver with normal and gentle guidance by the OB. This signified an obstetrical complication known as "shoulder dystocia." This complication results in a delay in delivery of a baby's body, usually caused, as in this case, by the top shoulder initially descending and becoming lodged behind his mother's pubic bone in his passage through the birth canal. (R. pp.171-172) The OB noted a loose nuchal cord, which she easily reduced. This means the umbilical cord was looped loosely behind the Son's neck, and the OB easily lifted it back over his neck. (R. pp. 193).

Standard obstetrical teaching provides several techniques and maneuvers to resolve the shoulder dystocia and deliver the baby injury-free. (R. pp. 543-546) Some of these are external to the mother's body and can be performed by nurses. (R. pp.175-181) Others are internal, meaning inside of the mother's birth canal. These can be performed only by a physician. (R. pp. 186-188; pp. 205-207)

The OB ordered the nurses to perform two external maneuvers in this delivery, one to change the Mother's leg position ("McRoberts") and the other to apply indirect pressure on the top shoulder just above the Mother's pubic bone ("suprapubic pressure"). These, plus normal and gentle traction by the OB, did not release the top shoulder. (R. pp. 174-178).

The OB cut an episiotomy. The recognized reason to do so in this context is to provide more room for an obstetrician's hand(s) inside the birth canal for internal maneuvers. (R. pp. 177). At that point three commonly used internal maneuvers were available for the OB to use to release the shoulder safely, with no increase in her traction on the baby's head or bending of his neck. Two involve rotation of the shoulder around the pubic bone ("Rubin's" and "Woods"). The other involves sweeping the baby's bottom arm across his chest to deliver the bottom shoulder before the top one. ("posterior arm delivery method"). (R. pp. 206).

Despite having cut the episiotomy, the OB chose not to take advantage of any of these common safety procedures for which she was trained. Instead, she chose to try to release the top shoulder by manipulating the Son's head. With the nurses performing suprapubic pressure according to her orders, the OB pulled his head and neck out and down. (R. pp. 94-95; pp. 117-122; pp. 184-186; pp. 207-216; p. 899; p. 902) His body delivered approximately sixty seconds after his head delivered. (R. pp. 172).

Upon delivery, the Son was noted to have traumatic injuries to the brachial plexus nerves on the right side of his neck. His right arm hung limp, paralyzed except for minimal movement of his fingers. (R. pp. 593-594; pp. 807-904) Three of his nerves have severe and devastating permanent damage. His C-5 and C-6 nerve roots are completely avulsed from his spinal cord; and the C-7 nerve root is partially avulsed. Avulsion means the nerve roots are actually pulled out from the spinal cord. (R. pp. 61) This reduced the chance for him to obtain much surgical improvement, as there is no live nerve near the spinal cord to which the "downstream" nerve tissue could otherwise have been reattached. He also had a large neuroma, encompassing the three injured nerves. That is like a large unhealed scab which further reduced his chance for surgical improvement. *Id*.

After multiple surgeries, extensive rehabilitation and therapy, the Son's right shoulder and arm have improved somewhat, but he has significant impairments and disabilities which are permanent. These include, among others, loss of muscle mass and strength, disfigurement, and reduced range of motion in his right arm in all directions. He will never be able to perform activities requiring two arms. He will have no use of his right arm except as a helper arm. He will experience fewer career opportunities and reduced earning capacity as well as future medical expenses. (R. pp. 93-111; pp. 281-287; pp. 297-324; pp. 378-389; pp. 393-428)

## STATEMENT OF THE CASE

Petitioner brought this action individually and as Next Friend of her Son. Petitioner alleged that the OB and Carolina OB-GYN ("OB Group," collectively, "Respondents"), negligently mismanaged the shoulder dystocia complication, thereby causing the permanent nerve injuries to her Son. (R. pp. 12-20).

Petitioner filed her Summons and Complaint on October 12, 2016; and the case was designated as Civil Action Number 2016-CP-22-00863. *Id.* On November 11, 2016, Respondents answered with general denials and assertions of numerous affirmative defenses. These include the affirmative defense under the Statute which, *inter alia,* grants tort immunity to an obstetrician providing medical care in certain emergencies in certain locations, unless the patient proves she was grossly negligent. (R. pp. 21-30) Petitioner filed an Amended Summons and Complaint on March 16, 2017, and it was answered on April 17, 2017, with no material defense added. (R. pp. 31-40)

Petitioner moved on October 17, 2018, for partial summary judgment to preclude the statutory defense under § 15-32-320 on the basis that, properly construed, it affords no defense in this case. (R. pp. 949-951) This motion was denied on December 17, 2018. (R. pp. 11-13)

The case went to trial against Respondents in the Georgetown County Court of Common Pleas beginning on April 1, 2019, with the Honorable Larry B. Hyman, Jr. serving as the trial judge for most of the trial. Trial started on a Monday and concluded that Friday, April 5, 2019. After the Respondents rested, Petitioner moved for a directed verdict in her favor on the statutory defense, based in part on the inapplicability of the statute as a matter of law. (R. pp. 806-809) The Court determined the statute presented questions of fact for the jury. (R. p. 809) During trial, a recently elected circuit court judge, the Honorable Bentley Price, had joined Judge Hyman at the bench to observe the trial proceedings. Judge Hyman invited Judge Price to preside over the closing arguments.

Over Petitioner's prior objections, the court's jury charges included the "genuine emergency situation" defense under the Statute; and the verdict form also contained this statutory defense. (R. p. 876) Over Petitioner's objection, the trial court gave the standard medical

malpractice hindsight charge, without qualifying that it applied only to the standard of care and not to medical instability and other factors. (R. p. 712, line 23-p.713, line 5)

The verdict form posed two initial questions: whether Petitioner had met her burden of proving (1) ordinary negligence; and (2) that such negligence was a cause of the child's damages. (R. pp. 4-5) The verdict form then directed the jury to stop deliberations if an answer was "no," but if both answers were "yes," to go to the following questions. These asked whether Respondents had met their burden of proving the elements of the Statute and, if "yes", whether Petitioner had met her burden of proving the OB was grossly negligent. *Id.*

The jury began their deliberations at 4:03 pm on Friday, April 5, 2019. The jury foreman informed the judge that the jury had been unable to agree on the answer to the first two questions, but the jury had reached a decision on the rest of the questions and asked if they could return a verdict on that basis. (R. pp. 881-890) Over Petitioner's objection, the court agreed to accept their partial verdict. *Id.* Deliberations concluded at 6:25 pm.

The verdict form returned by the jury did not answer whether Petitioner had met her burden of proving ordinary negligence as a cause of the Child's damages. However, after skipping those questions, the jury answered that Respondents had proven a qualifying emergency under the statute and that Petitioner had not proven that the OB was grossly negligent. (R. pp. 4-5)

After the jury was dismissed, Petitioner moved orally for a new trial, which the judge denied at that time, before Petitioner stated the grounds. (R. p. 895) Within ten days, on April 15, 2019, Petitioner filed alternative written motions, for (1) a new trial and (2) relief under Rule 59(e), SCRCP, to alter or amend the oral ruling. (R. pp. 952-965) The judge agreed to hear all the motions in full. Following a hearing on June 27, 2019, the judge denied Petitioner's motions. (R. pp. 6-8)

Petitioner timely served and filed her Notice of Appeal. (R. pp. 979-983) The Court of Appeals filed their decision on November 2, 2022, affirming the rulings below. Petitioner filed

and served her Petition for Rehearing on November 17, 2022, which was denied by Order dated March 30, 2023. The amount involved in this appeal exceeds One Million Dollars.

## STANDARD OF REVIEW

In an action at law, on appeal of a case tried by a jury, the appellate court may correct only errors of law. *Berberich v. Jack*, 392 S.C. 278, 709 S.E.2d 607 (2011), *Townes Assocs. v. City of Greenville*, 266 S.C. 81, 221 S.E.2d 773 (1976). Statutory interpretation is a question of law. *City of Newberry v. Newberry Elec. Co-op., Inc.,* 387 S.C. 254, 256, 692 S.E.2d 510, 512 (2010). The primary rule of statutory construction is to ascertain and give effect to the intent of the legislature. *Mid-State Auto Auction of Lexington, Inc. v. Altman,* 324 S.C. 65, 69, 476 S.E.2d 690, 692 (1996). Unless there is something in the statute requiring a different interpretation, the words used in a statute must be given their ordinary meaning. Id. When a statute's terms are clear and unambiguous on their face, there is no room for statutory construction and a court must apply the statute according to its literal meaning. *Sloan v. Hardee*, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007).An issue regarding statutory interpretation is a question of law. "Questions of statutory interpretation are questions of law, which the appellate court is free to decide without any deference to the court below." *Grier v. AMISUB of SC, Inc.* S.C. 532, 535, 725 S. E.2d 693, 695 (2012).

## ARGUMENT

### I. The Statute Must Be Strictly Construed Because it is Ambiguous, Without Clear Legislative Intent, and in Derogation of Common Law.

#### A. *The Statute is Ambiguous.*

In the Statute the General Assembly set forth four distinct requirements that a defendant physician must satisfy if she wishes to be immune from liability for her own acts of negligence

during an emergency. These requirements include (1) "genuine emergency situation;" (2) "immediate threat of death or serious bodily injury;" (3) "the patient is not medically stable;" and (4) treatment of the emergency was in one of three designated locations. Some of these words have common, plain usage in isolation, but not in the statutory context. The phrases must be interpreted to mean something other than an element of any medical emergency, or the General Assembly's purpose of providing qualified immunity for some but not all emergencies would be defeated. How they should be interpreted to avoid that result is unclear, and the phrases are thus ambiguous.

The phrase, "the patient is not medically stable" is the focus of this Petition. Two of the other phrases will be addressed briefly to illustrate that there are numerous ambiguities in the Statute.

**1. <u>Genuine Emergency Situation</u>.**

Petitioner has not located any definition of "genuine emergency situation" in any dictionary. However, "medical emergency" has been defined as "[a] serious and unexpected situation involving illness or injury and requiring immediate action." *See* https://en.oxforddictionaries.com/definition/medical-emergency. "Emergency" has been defined as "an unforeseen combination of circumstances or the resulting state that calls for immediate action;" and "an urgent need for assistance or relief." *See* https://www.merriam-webster.com/dictionary/emergency. The common features of these "emergency" definitions are the urgency and immediacy of needed medical intervention to avoid serious adverse effects on one's medical well-being.

In common usage of "genuine," all emergency situations are genuine, or they would not be emergency situations. A "genuine emergency situation" is a term of art, though undefined in the

statute. "Genuine emergency situation" must surely mean something more than "real emergency."[1] It is unlikely the legislature was worried the Statute would be applied to fake emergencies. If the word "genuine" means no more than "real," it is superfluous.

**2. Immediate Threat.**

Similarly, an "immediate threat of death or serious bodily injury" may be characteristic of all emergencies, depending on how it is defined. "Immediate" is sometimes defined as "now" or "instantaneous," without the passage of time. For example, definitions of "immediate" have been stated as follows: "occurring or accomplished without delay; instant;" "following or preceding without a lapse of time;" "of or relating to the present time or moment." *See* www.dictionary.com/browse/immediate. Other definitions are less precise like "soon" or "imminent," allowing for some degree of time lapse in the definition. To that extent, the word "immediate" is ambiguous.

**3. The Patient is Not Medically Stable.**

Compared to "genuine emergency situation" and "immediate threat," the phrase "the patient is not medically stable" provides more clarity. To be sure, Petitioner has found no definition of the phrase. However, in this context, it is helpful to analyze the key words, "the patient," "is" and "stable."

The significance of "the patient" is its requirement that medical stability must be determined for *this patient*, not a generic patient, another patient facing the same emergency, or all patients facing any emergency. The Statute does not address an unstable *condition*, *time*, or *situation*, which are characteristic of all emergencies. If the General Assembly intended any of

[1] One logical interpretation of the phrase is that a "genuine emergency" is one for which the physician in question has not received standard training. See, e.g., *See Amodeo v. Cumella*, 41 A.D. 3d 396 (N.Y. App. Div. 2007). Under this interpretation, for example, it would not be a "genuine" emergency if a physician in a specialty practice were called upon to manage an emergency for which specialists in the field are routinely trained, but the same emergency would be "genuine" for a primary care physician or one in a different specialty practice who had not received such training.

these to satisfy its patient instability requirement, it could have easily said "the *condition*…," "the *time*…," or "the *situation* is not medically stable," instead of "the *patient* is not medically stable."

"Is" represents a state of being. Merriam-Webster defines "is" as "the present tense third-person singular" of the word "be." *See*, https://www.merriam-webster.com. Collins Dictionary is to the same effect is to the same effect: "the third person singular of the present tense of be." *See*, https://www.collinsdictionary.com.

A concern, fear, or risk of patient instability is different from a patient in fact being medically unstable. Considering the definition of "stable" and "stability" in the next paragraph, the time to determine *the patient's* stability is in the present, the near past, just before the emergency is recognized, and the near future, right after the emergency has resolved.

In the medical context, "stable" has been defined as "steady; not varying; resistant to change." *See,* https://www.medilexicon.com/dictionary/84246. Merriam-Webster on-line does not provide a useful definition of "stable," but defines "stability," in pertinent part as: "the strength to stand or endure;" "the property of a body that causes it, when disturbed from a condition of equilibrium or steady motion to develop forces or moments that restore the original condition." *See,* https://www.merriam-webster.com.

These definitions highlight the significance of the patient's pre- and post-emergency condition. How else is one to tell if a patient had the strength and well-being to endure and resist the stress of a shoulder dystocia complication without ill effect if one ignores the pre- and post-emergency condition?

The General Assembly deliberately included "the patient is not medically stable" as one of the criteria which must be satisfied for a defendant physician to gain qualified immunity. In so doing, the legislature intended "the patient is not medically stable" to have meaning apart from the unstable situation inherent to any emergency. Otherwise, it would be superfluous.

Despite the clarity Petitioner sees in this phrase, it must be considered ambiguous, as the Court of Appeals accepted generalized testimony of an unstable *situation* as sufficient to create a factual question for the jury whether "the *patient* is not medically stable." See *Smalling v. Maselli*, Op. No. 5949 (S.C. Ct. App. filed November 2, 2022). Petitioner asserts the Court erred in doing so, but the Court's decision demonstrates there are different interpretations of the phrase, thus ambiguity.

**B. *The Legislative Intent is Unclear in Significant Part.***

"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. Statutory language must be construed considering the intended purpose of a statute. *Id*. Broad aspects of the legislative purpose are clear, but unfortunately, the ambiguous parts determine whether a plaintiff must prove ordinary negligence or gross negligence.

The General Assembly undoubtedly intended to provide physicians with immunity from liability for negligent medical care rendered by them in certain emergencies in certain locations. Just as clearly the legislature intended to retain common law liability for physician negligence in certain other emergencies or locations. This is plain from legislative limitations on (1) which emergency conditions may impart qualified immunity, such as "genuine emergency situation," "immediate threat," and "the patient is not medically stable;" and (2) which locations may qualify, an "emergency department," "obstetrical" or "surgical" "suite."

For a plaintiff to be required to prove gross negligence to prevail, the physician must first prove to the jury's satisfaction that she acted during a qualifying type of emergency in a qualifying location. These restrictions are ambiguous in the sense that they do not draw a bright clear line to

distinguish emergencies which entail qualified immunity from other emergencies which fail to satisfy one or more limiting criteria.

Courts must interpret the statutory criteria which stand as exceptions to qualified immunity in a way which preserves their purpose to keep every emergency from triggering qualified immunity. If ordinary elements of an emergency are allowed to satisfy the restrictive criteria, they would have no efficacy or purpose. This would be an absurd result, counter to legislative intent.

***C. This Statute 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. *Byrd, supra*. "[S]tatutes in derogation of the common law are to be strictly construed." *Id., 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.'" *Grier, supra,* citing *Crosby v. Glasscock Trucking Co.*, 340 S.C. 626, 628, 532 S.E.2d 856, 857 (2000).

The 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. *Grier, supra; Epstein, supra. 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.) Therefore, "genuine emergency situation,"

"immediate," and "the patient is not medically stable" require proof other than that which inheres within the concept of ordinary medical emergencies. Proving an emergency exists cannot satisfy restrictions on which emergencies are entitled to qualified immunity, or the restrictions would be construed into nothingness. Likewise, evidence sufficient to satisfy one requirement cannot also satisfy a different requirement, for then one or the other would be superfluous.

To construe the 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). These conditions and qualifiers must be given vigor to respect and effectuate legislative intent. The legislature intended for this Statute to be construed and applied to maintain a meaningful distinction between emergencies which involve stable patients from those "not medically stable." It is reversible error for a court to construe statutory conditions and qualifiers out of the Statute, thereby nullifying the purpose of the Statute and unnecessarily enlarging its departure from common law.

## II. The Court of Appeals Erred in Not Properly Construing the Statute and in Not Ruling that "the Patient" Was "Medically Stable," as a Matter of Law.

### A. *Respondents Conceded the Son was Medically Stable by all Measures Right Before and After the Shoulder Dystocia*

Experts for both sides admitted that all objective measures showed the Child was medically stable. As the Court of Appeals acknowledged, "the experts here agreed the data from the fetal heart monitoring strips, Apgar scores, and cord blood gases indicated stability." *Smalling,* Supra. This is telling. It is uncontroverted that the Child was objectively stable at the time shoulder dystocia was diagnosed and sixty seconds later when his body had delivered completely. This should have been held to establish medical stability of "the patient" *as a matter of law*.

### *B. The Statute Does Not Permit Respondents to Create a Jury Issue of the Patient's Instability by Inference From an Unstable Situation.*

Respondents' experts dodged this pivotal issue of the individual patient's stability *during the 60 seconds* of his shoulder dystocia. They generalized shoulder dystocia as being the same for all babies. This is illogical, incorrect, and offends the legislative intent that each emergency be evaluated for its effect on the individual patient involved. They next generalized that babies whose birth is complicated by shoulder dystocia are all unstable, no matter how stable the baby is at the outset; how short the shoulder dystocia's duration; how easy its resolution; and how stable the baby is at its resolution. This too is illogical, incorrect, and defies legislative intent.

For the Court to allow such generalized testimony to serve in this case as *prima facie* evidence that "the patient is not medically stable" is to permit all babies with a shoulder dystocia to be lumped together as a unit instead of being addressed individually, as the Statute requires. The Statute unquestionably mandates a distinction between patients in an emergency who are medically stable and unstable. This mandate would be negated by allowing an inference that a baby is unstable because his emergency, like all others, is an unstable situation.

The seriousness and risk of each shoulder dystocia varies. Some shoulder dystocia emergencies are relatively easier to resolve, with lesser risks, and others more difficult with significant risks.

The former includes a patient who is in fact medically stable, evidenced by (1) reassuring fetal heart monitoring right before shoulder dystocia; and (2) Apgar scores and (3) cord blood gases which are very good right after the baby delivers[2]. These typically involve delivery of the

[2] In some emergencies there may be direct evidence of patient (in)stability, but not shoulder dystocia. Without direct evidence, the only reasonable way to distinguish stable patients from those "not medically stable" in the shoulder dystocia context is to examine direct evidence of the patient's medical stability status before the diagnosis and after the baby's body has delivered. Instability before would be probative of a "not medically stable" patient, as would a

body in less than four minutes after the head delivers. An excellent example is the sixty second shoulder dystocia in this case involving a baby with highly reassuring health, by all measures, both before and after the dystocia. It is this type of emergency for which the Statute should be construed as preserving liability for a physician's ordinary negligence.

Shoulder dystocia complications which are relatively more difficult to resolve, and with higher risks, involve features such as (1) non-reassuring fetal heart tracings right before the shoulder dystocia diagnosis; and (2) a baby stuck in the birth canal for more than four or five minutes. Such delay in resolution of the dystocia reflects its difficulty to resolve and the increasing risk of hypoxia as more time passes. These patients may not be medically stable, *at least* during the latter stages of the emergency. Especially poor fetal heart monitoring tracings, suggestive of already impaired oxygenation and ongoing depletion of fetal reserves, serves as a good example of how medical instability should be construed under the statute. Low Apgar scores and acidotic cord blood gases after delivery would confirm that a baby was unstable during the shoulder dystocia. It is this latter type of shoulder dystocia emergency for which the Statute confers qualified immunity. If a tort claim is brought following injury in this context, liability should be determined under the gross negligence liability standard, assuming all other statutory criteria are met.

Despite the Son being a pristine example of a medically stable baby, Respondents' experts tried to wrestle the facts of this case into the latter category. In this effort they testified that (1) shoulder dystocia is always an unstable condition[3], and risk of complications makes it an emergency and unstable time[4]; and (2) that this child was "not medically stable" because all babies

deteriorated state afterwards. Medical stability before and after are compelling proof that the patient was actually and contemporaneously stable during the shoulder dystocia.

[3] Dr. Chauhan testified to an unstable condition (R. p. 757, line 18 – p. 758, line 9; p. 758, line 20 – p. 759, line 2)

[4] Dr. Duchowny testified to this effect. (R. p. 911, part 8, lines 2-4; p. 913, part 22, lines 25-5). He testified that shoulder dystocia is an unstable time. (R. p. 914, part 23, lines 20-23).

are medically unstable during unstable shoulder dystocia complications. (R. p 640 – 642, 753, 757, 758, 759, 911, 914).

Shoulder dystocia is of course an unstable condition, time and situation, or it would not be an emergency. It is fair to call all medical emergencies unstable situations. However, this provides no information about medical stability of the Son, or any individual patient, as required by the Statute.

Respondents rely on the testimony of three experts for proof of medical instability, but none focused on the Son himself as a patient. Dr. Robinson cleverly told the jury that "You cannot be stable and not be able to breathe." (R. p. 705, lines 1-2) Many fetuses would disagree if they could talk, but they cannot talk or breathe. Dr. Robinson was presumably speaking about oxygenated blood flow through the umbilical cord being disrupted by shoulder dystocia. Such testimony is overbroad and does not represent this dystocia or this patient, as the Statute requires, because umbilical cord compression varies from one shoulder dystocia complication to another. Moreover, it is incorrect, using statutory definitions of "stable" and "stability." See p. 10, *supra*.

Dr. Robinson admitted that the Son was born in excellent health, with no hypoxia. (R. pp. 642-643) Nevertheless, he persisted in his assertion that the Son's excellent health before and after the sixty second dystocia had no bearing on whether he was medically stable during these sixty seconds.

Ironically, Respondents in their briefing and the Court of Appeals 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. (R. pp. 642-643) Doing a fine job does not cause severe and permanent brachial plexus nerve damage, and healthy oxygen status does not foreclose a finding

that physician negligence caused the injuries. What healthy oxygen status post-birth does do is emphasize medical stability during the sixty second shoulder dystocia emergency. Though Respondents' testimony about the significance of healthy oxygen status post-birth misses the mark, it is worth noting that Respondents considered it proper to call such post-birth testimony to the Court's attention, while arguing that the jury should be precluded from consider post-birth facts. Whatever else one may say about Dr. Robinson's testimony, he provided no evidence whatsoever that *this patient*, in the moment, was medically unstable within the meaning of dictionaries and the Statute.

Respondents also proffered testimony of Dr. Chauhan to try to prove the patient was medically unstable. The testimony does no such thing. Dr. Chauhan spoke only of an unstable *condition.* (R. p. 757, line 18-p. 758, line 9; p. 758, line 20-p. 759, line 2).

To similar effect is Dr. Duchowny's testimony. He spoke of shoulder dystocia as a medically unstable *time*. (R. p. 914, part 23, lines 20-23).

### C. *The Court of Appeals Erred in Evaluating the Respondents' Experts' Testimony without First Construing the Statute*

The Court of Appeals erroneously held that testimony of an unstable situation created a jury question whether "the patient" was "not medically stable." The Court cited *Byrd as Next Friend of Julia B. v. McLeod Physician Assocs. II*, 427 S.C. 407, 831 S.E.2d 152 (Ct. App. 2019), for its assertions that: "As in Byrd, the experts here agreed the data from the fetal heart monitoring strips, Apgar scores, and cord blood gases indicated stability … the experts seem to agree the data from the fetal heart monitoring strips, Apgar scores, and cord blood gases indicated stability" but "medical stability is not based on this information alone." *Smalling*, *supra*. (Internal citations omitted.) The Court of Appeals also cited *Byrd* in summarizing Respondents' testimony as

"shoulder dystocia is a medically unstable situation because if the baby is not timely delivered, lack of oxygen can lead to brain injury or death." *Smalling*, supra.

In these respects, and others, *Byrd* was wrongly decided. There was no Petition for Writ of *Certiorari* filed in that case, so this Court has not considered these issues.

The testimony of Respondents' experts does not support the Court's decision for four reasons. First, the Court overlooked the need to construe "the patient is not medical stable" before addressing whether evidence of an unstable situation was sufficient to create a question of fact for the jury on the issue. In the medical context, the phrase "stable" or "stability" means resistant to change; having the strength to withstand or endure; and "the property of a body that causes it, when disturbed from a condition of equilibrium … to develop forces … that restore the original condition." See p. 10, *supra*.

Based on the concessions of Respondents' experts that the Son was medically stable right before and right after the shoulder dystocia, he was medically stable *as a matter of law* using basic dictionary definitions. It is not necessary to strictly construe the Statute to reach that conclusion, but strict construction mandates that result. The Son successfully resisted change to his condition from the shoulder dystocia. He had ample strength to withstand and endure the shoulder dystocia with no adverse effect on his health. He had the ability to restore his reassuring, very good health status from diagnosis of the shoulder dystocia through delivery of his body sixty seconds later[5].

Second, every emergency is an unstable situation, or it would not be an emergency. Observing that a particular emergency involves an unstable situation does no more than point to

[5] Respondents' arguments postulate the Son was medically stable, in very good health, up until the diagnosis of shoulder dystocia, then unstable for one minute until his body delivered, at which time he was again medically stable and in very good health. It follows from this argument that the purported instability was temporary, of short duration, and of a *de minimus* nature. Temporary *de minimus* changes are implicit in any healthy baby's passage through the birth canal, not only in a baby whose passage is complicated by a one-minute shoulder dystocia. Dictionary definitions of "stable" and "stability" encompass temporary *de minimus* changes.

one of several elements which define an emergency. A statutory requirement intended to limit which emergencies attain qualified immunity cannot be satisfied by presenting evidence that an element of an emergency was present in this case.

Third, the Court impermissibly accepted evidence of one statutory limitation, i.e., "threat of death or serious bodily injury" as *prima facie* evidence of another, i.e., that "the patient is not medically stable." Depending on the statutory construction of "immediate," the risk of brain injury or death might satisfy the "immediate threat" requirement. However, if evidence of an immediate threat were accepted as *prima facie* evidence of medical instability, this would make one requirement or the other superfluous.

Fourth, the Respondents' experts' testimony, and the Court of Appeals' evaluation of it, addressed shoulder dystocia situations and babies generally, without focusing on *this patient*. The Statute recognizes some emergency patients will be medically stable and others will not. This will never occur if one is allowed to infer patient instability from an "unstable situation."

The Statute does not permit an inference that every baby whose delivery is complicated by shoulder dystocia is not medically stable, just because the situation itself is unstable. There would be no meaning to the legislative distinction between emergency patients who are medically stable and those who are not. Allowing such an inference would defy legislative intent to preserve a medically stable patient's ability to prevail in a tort action upon proof of physician negligence in an emergency.

The Court of Appeals' Decision endorses the concept that evidence of an "unstable situation," characteristic of every emergency, permits an inference that an emergency patient is "not medically stable." This is error because it 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 "the patient" who is medically stable in the statutory sense despite the emergency, and other patients who are not.

The sole purpose of restrictive conditions and qualifiers in a statute is to ***limit*** application of the statute. In the present case, restrictive conditions and qualifiers in the Statute are there to ensure the Statute is applied to fewer than all emergencies. If the Court does not preserve and protect the statutory limitations, it fails to honor legislative intent. The Court should rule in this statutory context that an unstable condition, time, or situation is not, as a matter of law, *prima facie* evidence of a medically unstable patient. Otherwise, legislative enactment of limitations to applicability of the Statute would be an exercise in futility.

The trial court and the Court of Appeals incorrectly construed the limiting phrase, "a patient must not be medically stable" to render it meaningless surplusage. 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".) See also, *Ranucci v. Crain,* 409 S.C. 493, 763 S.E.2d 189 (2014).

## III. The Court of Appeals Erred in Not Ruling that the Trial Judge Committed Prejudicial Error in Giving a Hindsight Charge Without Explaining that an Infant's Post-Birth Condition May Properly Be Considered to Evaluate Medical Stability.

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. Facts not knowable until later are not relevant to evaluating physician negligence at an earlier time. 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.

Post-birth evidence probative of medical stability is materially different. Petitioner had every right to have the jury consider her post-birth evidence in determining whether Respondents had met their burden of proving the Minor was "not medically stable." Indeed, the patient's stability is proven by post-birth evidence, in addition to the Son's stability when shoulder dystocia was diagnosed. See definitions of "stable" and "stability" on pages 10, *supra*. To instruct the jury not to consider post-birth evidence in their deliberations was prejudicial because it was the Petitioner's strongest evidence that her son was medically stable throughout. Medical stability was the primary basis on which Petitioner relied to avoid having to prove gross negligence under the Statute. Succeeding on the issue would have negated the statutory defense, allowing Petitioner to prevail by proving ordinary negligence.

The trial judge gave the following hindsight charge to the jury: "In considering whether the defendant made a reasonable decision, you must consider the decision in relation to the facts as they existed at the time and not in the light of what hindsight may reveal." (R. p. 869-870). This charge was given over Petitioner's objection. (R. p. 712-713).

The trial judge did not err by giving a hindsight charge, but he did err by failing to explain that the jury could nevertheless properly consider post-birth evidence on the medical stability question. Respondents have the burden of proof to satisfy all the restrictive criteria, including medical instability, and they have cited no authority that would preclude the use of post-birth evidence to establish medical stability.

The trial judge should not have given this charge without clarifying that post-birth evidence may be considered on the medical stability issue. Without such clarification, the charge was prejudicial to Plaintiff. It directed the jury to disregard probative evidence that the patient was indeed medically stable, which would have rendered the Statute inapplicable. Instead, the found medical instability and no gross negligence. But for the improper charge, the probability is the jury would have not applied the Statute and would not have reached the gross negligence issue in their deliberations.

## CONCLUSION

For the reasons stated, the decision of the Court of Appeals should be reversed, and the case remanded for a new trial with the statutory defense under S.C. Code Section 15-32-230 being precluded.

Respectfully submitted,

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May 30, 2023
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