THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

Steven H. John, Circuit Court Judge

Case No.: 2011-CP-46-00683

Samantha Jamison, as Personal Representative of the Estate of Jayden Joenelle Jamison-Barber, deceased.....Respondent,

v.

Ansley L. Hilton, MD, individually and as agent, servant or employee of Rock Hill Gynecological and Obstetrical Associates, PA; Christopher B. Benson, MD, as agent, servant or employee of Rock Hill Gynecological and Obstetrical Associates, PA; and Rock Hill Gynecological and Obstetrical Associates, PA, Defendants,

Of whom,

Rock Hill Gynecological and Obstetrical Associates, PA, is the.....Appellant.

INITIAL APPELLANT'S BRIEF

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STATEMENT OF THE ISSUE ON APPEAL

Did the trial court err in denying the Practice's motions for judgment as a matter of law, where the jury returned defense verdicts in favor of the Practice's doctors who were named as defendants and there was no expert testimony that negligence by any of the Practice's other employees proximately caused the Respondent's claimed damages?

STATEMENT OF THE CASE

This medical malpractice action stems from the sudden and unexplained death of the Respondent's baby before he was delivered. Numerous experts on both sides were involved in this case, but none of them could say to a reasonable degree of medical certainty why the baby died. In fact, the experts hesitated even to speculate about the cause. Consequently, despite a week-long trial, the cause of death remains a mystery to this day.

The Respondent filed a Summons and Complaint in the Court of Common Pleas for York County in 2011. [Summons and Complaint.] The Complaint listed the following defendants: (1) Ansley L. Hilton, M.D., (2) Christopher B. Benson, M.D., and (3) Rock Hill Gynecological and Obstetrical Associates, P.A. [Complaint.] The Complaint alleged that Drs. Hilton and/or Benson committed malpractice that led to the pre-delivery death of the Respondent's son Jayden. [Complaint.] All of the named defendants filed and served a timely Answer denying those allegations. [Answer.]

After a full period of discovery, the case was called to trial before the Honorable Steven H. John on April 8, 2013. The Respondent offered her own testimony, as well as that of several family members. The Respondent also presented the testimony of two experts, who opined that the negligence of Drs. Hilton and/or Benson proximately caused

the baby's death, or at least reduced his chances for survival. [Trial Trans., pp. 150-57, 268-78.] However, the experts did not testify as to any causal connection between the death and the acts or omissions of other employees of the defendant Rock Hill Gynecological and Obstetrical Associates, P.A. The defendants moved for a directed verdict on several grounds at the end of the Respondent's case-in-chief, but the trial judge denied the motion. [Trial Trans., pp. 324-25.]

The defendants presented several witnesses, both live and by deposition. The defense witnesses included two experts, who said the defendant doctors did not breach the applicable standard of care and did not cause the baby's death. At the close of their case, the defendants renewed their directed verdict motions, which the trial judge again denied. [Trial Trans., pp. 865-66.] The Respondent did not present any rebuttal witnesses or evidence.

After giving the jury instructions that drew no objections from either side, the trial judge submitted the case to the jury on April 12, 2013. The jury deliberated for several hours before returning a verdict at approximately 9:00 pm. [Trial Trans., pp. 958-60.] The verdict form consisted of three questions for the jury to answer. In response to the first two questions, the jury found that neither Dr. Hilton nor Dr. Benson committed any negligence that proximately caused damages to the Respondent. [Trial Trans., p. 959.] Responding to the third question, however, the jury found that the defendant Rock Hill Gynecological and Obstetrical Associates, P.A. was negligent. [Trial Trans., pp. 959-60.] The jury awarded the Respondent $90,000 in damages against Rock Hill Gynecological and Obstetrical Associates, P.A. [Trial Trans., p. 960.]

The trial judge denied the defendants' request for 10 days to make post-trial motions. [Trial Trans., p. 964.] The defendants then made oral motions for a new trial or, in the alternative, for judgment as a matter of law. [Trial Trans., pp. 964-65.] The trial judge denied those motions from the bench. [Trial Trans., pp. 966-68.] On April 25, 2013, the defendants filed a written motion pursuant to Rule 59(e), which the trial judge denied in an Order filed on July 15, 2013. [Motion; Order.] The Appellant then filed and served a timely Notice of Appeal in this Court on August 9, 2013. [Notice of Appeal.] The Respondent did not appeal the defense verdicts in favor of Drs. Hilton and Benson, which are now the law of this case.

STATEMENT OF THE FACTS

The Appellant Rock Hill Gynecological and Obstetrical Associates, P.A. ("the Practice") assumed the pre-natal care of the Respondent Samantha Jamison a little over halfway through her pregnancy. [Trial Trans., p. 79.] The Practice took Jamison on as a patient through an arrangement in which it agreed to provide OB-GYN care to lower income patients. [Trial Trans., p. 565.] Jamison came to the Practice as a patient with pregnancy risks due to her chronic hypertension, but she had no specific complications or problems as of her first office visit on July 18, 2008. [Trial Trans., pp. 79.]

On August 9, 2008, Jamison went to the emergency room complaining of lower abdominal pain. [Trial Trans., pp. 359-61.] Dr. Gregory Miller, a physician with the Practice, attended to Jamison at the hospital. [Trial Trans., pp. 359-61.] After noting an elevated blood pressure reading for Jamison, Dr. Miller conducted a series of tests that ruled out pre-term labor. [Trial Trans., pp. 364-67.] The lab results, including blood work and a urinalysis, also revealed no medical grounds for intervention or immediate

treatment. [Trial Trans., pp. 369-75.] For that reason, Dr. Miller discharged Jamison and told her to keep her next scheduled office visit at the Practice. [Trial Trans., pp. 378-79.]

Jamison returned to the Practice for a checkup on August 25, 2008, and again saw Dr. Miller. [Trial Trans., p. 381.] Jamison's only complaint that day was of swelling in her left ankle. [Trial Trans., p. 403.] Based on an examination of Jamison and the results of tests he conducted, Dr. Miller found no complications or dangers with the pregnancy. [Trial Trans., p. 409.] Dr. Miller did not order a non-stress test at that visit because it was not indicated under the applicable medical standards. [Trial Trans., p. 409.] Notably, Jamison had no complaints of decreased fetal movement when she saw Dr. Miller on August 25, 2008. [Trial Trans., p. 400.] Dr. Miller nevertheless instructed Jamison to start doing "kick counts," something he recommended to all of his pregnant patients. [Trial Trans., pp. 406-07.] Those "kick counts" allow patients to monitor the timing and frequency of their babies' movement. [Trial Trans., pp. 406-07.]

On the morning of September 5, 2008, Jamison became concerned about feeling the baby move less frequently, and she went to the Practice although she did not have an appointment. [Trial Trans., pp. 86, 112.] Jamison arrived at the office a little before 9:00 that morning, by which time there were already nineteen patients ahead of her on the sign-in sheet. [Trial Trans., pp. 173-74.] The first available professional was nurse practitioner Robin Pruitt, who examined Jamison. [Trial Trans., pp. 89, 484.] The examination included taking Jamison's blood pressure and checking the fetal heartbeat. [Trial Trans., p. 89.] Based on the results of the examination, Pruitt ordered a non-stress test to get more information about the baby's condition. [Trial Trans., p. 89.] The non-

stress test, which was performed by a qualified nurse, took roughly thirty minutes. [Trial Trans., pp. 116-17, 329-31.]

After the non-stress test, the nurses told Jamison they were going to do a biophysical profile, which would evaluate the baby's movement, among other things. [Trial Trans., p. 91.] A trained sonographer named performed that test in the office. [Trial Trans., p. 453.] The biophysical profile ran for approximately ten minutes, during which time the baby had a normal heart rate. [Trial Trans., p. 458, 495.] After the ten minutes had elapsed, Dr. Ansley Hilton entered the testing room and looked over the preliminary results. [Trial Trans., pp. 494-95.] Dr. Hilton determined that the baby was in a breach presentation and was not moving as much as a 32-week old fetus normally would be expected to move. [Trial Trans., pp. 494-95.] Dr. Hilton then stopped the test early because she wanted to send Jamison to the hospital in case any emergency treatment wound up being necessary. [Trial Trans., p. 495.]

After stopping the biophysical profile, Dr. Hilton instructed Jamison to go straight to the Labor and Delivery section of the hospital, which was approximately five minutes away from the office. [Trial Trans., p. 496.] Dr. Hilton emphasized her point by stating colloquially that Jamison should not "pass Go or collect $200" on her way to the hospital. [Trial Trans., p. 496.] Before releasing Jamison, Dr. Hilton confirmed that Jamison had transportation to the hospital and knew how to get to the Labor and Delivery section. [Trial Trans., pp. 120, 496.] Dr. Hilton then called the Labor and Delivery section to explain the situation and inform them that Jamison would be arriving soon. [Trial Trans., p. 497.] During her phone call to the hospital, Dr. Hilton also discussed Jamison's case with Dr. Christopher Benson, another physician with the Practice who was on call at the

hospital that morning. [Trial Trans., p. 497.] After that conversation, Dr. Benson got everything ready at the hospital for an emergency C-section in case one had to be performed. [Trial Trans., p. 562.]

According to Jamison, the admissions process at the hospital (which did not involve any of the Practice's employees) took around thirty minutes. [Trial Trans., p. 94.] A hospital employee then took Jamison to a room where other hospital staff members examined her. [Trial Trans., p. 95.] The nurses involved in that examination called Dr. Benson to notify him that Jamison had arrived, but that they could not find a fetal heartbeat. [Trial Trans., p. 561.] Dr. Benson got to the room within two minutes of receiving the call and performed an ultrasound. [Trial Trans., p. 597.] He was also unable to find a fetal heartbeat, even though he did the ultrasound twice, and he was forced to inform Jamison that the baby was deceased. [Trial Trans., pp. 96-97.] Later that day, at Jamison's request, a C-section was performed. [Trial Trans., pp. 98-99.]

More than five years have passed since this tragic event, and still no one has been able to determine when or why the baby died. No cause of death was established at the time, and the two doctors who treated Jamison that day (Drs. Hilton and Benson) could not say why the baby died. [Trial Trans., pp. 512, 598-600.] Similarly, the experts retained by both sides for trial were unable to offer opinions as to what caused the death, or when exactly it occurred. [Trial Trans., pp. 299, 803-04.]

STANDARD OF REVIEW

"A directed verdict should be granted where the evidence raises no issue for the jury as to the defendant's liability." *Guffey v. Columbia/Colleton Reg'l Hosp., Inc.*, 364 S.C. 158, 163, 612 S.E.2d 695, 697 (2005). "When reviewing the denial of a motion for

directed verdict or JNOV, this Court must employ the same standard as the trial court by viewing the evidence and all reasonable inferences in the light most favorable to the nonmoving party. ... The trial court must deny the motions when the evidence yields more than one inference or its inference is in doubt." *Welch v. Epstein*, 342 S.C. 279, 299-300, 536 S.E.2d 408, 418-19 (Ct. App. 2000). "This Court will reverse the trial judge's ruling only when there is no evidence to support the ruling or it is controlled by an error of law." *Town of Hollywood v. Floyd*, 403 S.C. 466, 744 S.E.2d 161, 168 (2013).

ARGUMENT

The trial court erred in failing to grant judgment as a matter of law to the Practice because there was no legal or evidentiary basis for a finding of liability against the Practice.

At trial, the Respondent focused her efforts almost entirely on allegations of malpractice by Drs. Hilton and Benson. Most of the fact witnesses testified about the Respondents interactions with those doctors, and the expert witnesses disputed whether or not the doctors had violated the applicable standards of care. Although one of the Respondent's experts questioned other aspects of the Respondent's care, he never attributed the baby's death to the acts or omissions of any medical professionals other than Drs. Hilton or Benson. For this reason, when the jury returned defense verdicts for those doctors, but also a verdict against the Practice, the trial court should have corrected the inconsistency by granting the Practice judgment as a matter of law. The failure to grant that relief was reversible error.

I. The defense verdicts in favor of Drs. Hilton and Benson prevented any finding of vicarious liability for the Practice.

It is clear that nothing in the care and treatment provided by Drs. Hilton and Benson could subject the Practice to vicarious liability. After hearing all of the evidence, the jury found in favor of those named defendants, exonerating them from any fault. Those decisions by the jury operated as a *de facto* defense verdict for the Practice as to any claims based on the alleged negligence of Dr. Hilton or Dr. Benson. This result is automatic under South Carolina law.

As our Supreme Court has explained:

> where a principal and agent or master and servant are jointly sued and the only evidence of negligence relates to acts committed by the agent or servant and the verdict of the jury exonerates the latter, a verdict against the principal or master cannot stand.

Brown v. National Oil Co., 233 S.C. 345, 347-48, 105 S.E.2d 81, 82 (1958). In the present case, the jury found that Drs. Hilton and Benson were not liable for anything they did (or failed to do) in their treatment of the Respondent. As a matter of law, therefore, none of those doctors' allegedly negligent acts or omissions could serve as the basis for a verdict against the Practice.

This is significant because the Respondent's case at trial dealt almost entirely with the treatment provided by Dr. Hilton and Dr. Benson on the day of the infant's death. The Respondent's experts, in particular, focused their opinions on how Dr. Hilton and Benson deviated from the applicable standard of care in their treatment of the Respondent. Despite those efforts, the jury concluded Drs. Hilton and Benson did not commit any malpractice that resulted in damages to the Respondent. Those defense verdicts effectively rejected the Respondent's primary claims and arguments at trial. The

Respondent's prevailing theme was that Drs. Hilton and Benson failed to care for her properly under the circumstances existing on September 5, 2008. That theory obviously failed, as did the claims based on it.

As a result, a verdict against the Practice could only have been legally valid if negligence by some other employee proximately caused the Respondent's claimed damages. In other words, for the verdict to stand there must be evidence that some other employee of the Practice committed negligent acts or omissions that caused the baby's death. As discussed below, the record is devoid of any such evidence, and the verdict against the Practice should be reversed.

II. The record contains no support for any verdict against the Practice based on acts or omissions of employees other than Dr Hilton and Dr. Benson.

The jury determined that Drs. Hilton and Benson were not negligent in their treatment of the Respondent and/or that any negligence on their part did not proximately cause any of the claimed damages. Those defense verdicts prevented any finding of liability against the Practice based on the conduct of Drs. Hilton and Benson. Thus, in order for the verdict against the Practice to stand, there must be record evidence of malpractice by other employees that proximately caused damages to the Respondent. No such evidence exists in the record, however, and this Court should reverse the verdict in the Respondent's favor and remand for entry of judgment for the Practice.

(A) Legal Standards

"A plaintiff in a medical malpractice case must establish by expert testimony both the standard of care and the defendant's failure to conform to the required standard, unless the subject matter is of common knowledge or experience so that no special learning is needed to evaluate the defendant's conduct." *Carver v. Medical Soc. of SC*,

286 S.C. 347, 350, 334 S.E.2d 125, 127 (Ct. App. 1985). "In addition to proving the defendant negligent, the plaintiff must also prove that the defendant's negligence was a proximate cause of the plaintiff's injury." *Id.* "Proof of proximate cause must also be established by expert testimony when either the origin of the injury is obscure and not readily apparent to the layperson or where there are several equally probable causes of the condition." *Id.* To establish proximate cause, a plaintiff must present evidence that "rises above mere speculation or conjecture." *Id.* Furthermore, "[w]hen expert testimony is the only evidence of proximate cause relied upon, the testimony must provide a significant causal link between the alleged negligence and the plaintiff's injuries, rather than a tenuous and hypothetical connection." *Hoard v. Roper Hosp., Inc.*, 387 S.C. 539, 547, 694 S.E.2d 1, 5 (2010).

(B) Allegations Against Other Employees

As previously discussed, almost all of the evidence at trial focused on what Drs. Hilton and Benson did, or failed to do, in their treatment of the Respondent on September 5, 2008. However, viewing the evidence in the light most favorable to the Respondent, she arguably asserted two additional allegations that were not directed specifically to Drs. Hilton and Benson. First, the Respondent alleges another physician in the Practice (Dr. Gregory Miller) was negligent in failing to order a non-stress test when he saw the Respondent in the office on August 25, 2008.[1] Second, the Respondent claims she should not have had to wait as long as she did to see a treatment provider on the morning

[1] The Respondent attempted to argue at trial that Dr. Miller violated the standard of care, despite the fact that she never named him – or attempted to add him – as a defendant in the action.

of September 5, 2008. An examination of these allegations reveals that they do not provide a sufficient legal basis for a verdict against the Practice.

(1) August 25, 2008 Office Visit

On August 25, 2008, the Respondent had an office visit with Dr. Gregory Miller. The Respondent had only one complaint that day, which was swelling in her left ankle. [Trial Trans., p. 403.] The Respondent had not experienced and did not report any decreased fetal movement at that time. [Trial Trans., pp. 406-07.] Dr. Miller examined the Respondent and found no complications or dangers with the pregnancy. [Trial Trans., p. 409.] For that reason, Dr. Miller did not order a non-stress test, which was not indicated by the applicable medical standards. [Trial Trans., p. 409.] Although a non-stress test would not have harmed the Respondent, there was simply no medical reason to perform one. After the office visit on August 25, the Respondent did not return to the Practice for any reason until September 5.

The Respondent's ob-gyn expert, Dr. Douglas Phillips, expressed an opinion that Dr. Miller breached the applicable standard of care by not ordering a non-stress test and biophysical profile either during the office visit on August 25, 2008, or within one week of that visit. [Trial Trans., p. 256.] The expert believed those tests were necessary due to the Respondent's chronic hypertension. [Trial Trans., pp. 250-51, 256.] However, the expert could offer nothing more than vague speculation as to what tests conducted on that date might have revealed. [Trial Trans., p. 284.] The expert never testified with *any* degree of probability (let alone certainty) that the results of such tests would have indicated a need for immediate medical intervention. The expert implied there would

have been more time for such intervention if the test results *had* warranted it, but he had no basis to say poor test results would have been likely.

More significantly, the expert also failed to offer an opinion that the alleged breach of care by Dr. Miller proximately caused the baby to die. The expert testified at trial that Dr. Miller was not "directly" responsible for the baby's death. [Trial Trans., p. 303.] Although the expert tried to claim Dr. Miller's alleged negligence might have "contributed" to the baby's death, he ultimately backtracked and agreed that the opinion stated in his deposition ("I don't think Dr. Miller caused the baby to die") was still his opinion at trial. [Trial Trans., p. 303.] Furthermore, even before reaffirming that original opinion, the expert never said or indicated that Dr. Miller's acts or omissions most probably caused or contributed to the baby's death.

(2) Wait Time on September 5, 2008

Despite not having an appointment, the Respondent went to the Practice on the morning of September 5, 2008, because she was concerned about feeling less fetal movement. [Trial Trans., p. 86, 112, 173-74.] The Respondent arrived shortly before 9:00 am and signed the intake sheet, which indicated she was the twentieth patient on the waiting list. [Trial Trans., pp. 173-74.] There is no evidence she asked to be seen immediately or that she was in any acute distress.

Due to the high volume of patients, the Respondent waited for about an hour before the first available care provider saw her. [Trial Trans., pp. 484-85.] The nurse practitioner who saw the Respondent ordered a non-stress test, which revealed a fetal heartbeat within normal limits. [Trial Trans., pp. 486-93.] Nevertheless, the nurse practitioner decided to conduct a biophysical profile to obtain more information about the

baby. [Trial Trans., p. 337.] All of the medical experts at trial agreed the baby was alive when Dr. Hilton cut that biophysical profile short and told the Respondent to go immediately to the hospital shortly before 11:00 am.

One of the Respondent's experts (Dr. Douglas Phillips) testified that it was a breach of the applicable standard of care not to move the Respondent to the front of the waiting list based on her complaints of decreased fetal movement. [Trial Trans., p. 259.] The expert further stated it was a breach of the standard of care to make the Respondent wait for more than an hour before seeing a care provider when she presented with that complaint. [Trial Trans., p. 259.] As the Dr. Hilton explained without contradiction, however, complaints of decreased fetal movement do not always (or even usually) indicate a serious problem or risk to the fetus. [Trial Trans., pp. 484, 519-20.] The expert also had no way of knowing, and never addressed, whether the nineteen patients ahead of the Respondent on the list had similar or more serious complaints. Thus, the expert offered nothing more than a statement that "ideally" a caregiver should have seen the Respondent sooner.

It is debatable at best whether the expert's statement constituted a sufficient opinion regarding a breach of the standard of care. For purposes of this appeal, however, it is unnecessary to address that issue. The primary flaw with regard to this allegation of malpractice is the absence of sufficient expert testimony regarding proximate cause.

During the direct examination of the expert, the following exchange occurred:

> Q: Doctor, do you have a conclusion to a reasonable degree of medical certainty as to whether or not that delay in treatment caused or contributed to Jayden's death, the death of Samantha's son?
>
> A: Yes, it did.

[Trial Trans., p. 259, lines 20-24.] Despite giving this answer, the expert did not go on to explain *why* or *how* a delay of 60-80 minutes in performing the two tests caused the baby's death. The only attempted explanation came much later, when the expert gave the following response:

> [The baby] would have lived because there wouldn't have been the delay in doing those two tests, and there wouldn't [sic] been subsequent delay in getting the patient to the hospital as there was in this particular case. You had delays with the testing; you had delays from the time the patient left the hospital (sic) to the time she arrived in labor and delivery. Those delays were sufficient enough for a normal heartbeat that was present at 158 beats per minute in the office to end up with no heartbeat when she finally got there and they attempted to find the heartbeat after she got there on admission. So those delays, the delay from the leaving the office to getting to labor and delivery as well as the delays in performing those two tests resulted in the demise of [the baby.]

[Trial Trans., p. 277, lines 3-20.] Stated more simply, the expert suggested the baby could have survived if the Respondent had gotten to labor and delivery at the hospital sooner on September 5, 2008. As discussed below, however, this was nothing more than unsupported speculation, and it did not serve as sufficient expert testimony to establish a causal link between the time the Respondent spent at the doctor's office and the baby's death.

(3) Absence of Sufficient Probable Cause Evidence

It is well settled that a plaintiff in a medical malpractice case must "prove that the defendant's negligence was a proximate cause of the plaintiff's injury." *Carver v. Medical Soc. of South Carolina*, 286 S.C. 347, 350, 334 S.E.2d 125, 127 (Ct. App. 1985). The plaintiff must establish proximate cause by expert testimony "where either the origin

of the injury is obscure and not readily apparent to a layperson or where there are several equally probable causes of the condition." *Id.* "When one relies solely upon the opinion of medical experts to establish a causal connection between the alleged negligence and the injury, the experts must, with reasonable certainty, state that in their professional opinion, the injuries complained of most probably resulted from the defendant's negligence." *Hoard v. Roper Hosp., Inc.*, 387 S.C. 339, 546, 694 S.E.2d 1, 5 (2010). "When expert testimony is the only evidence of proximate cause relied upon, *the testimony must provide a significant causal link between the alleged negligence and the plaintiff's injuries, rather than a tenuous and hypothetical connection.*" *Id.* at 546-47, 694 S.E.2d at 5 (emphasis added).

Here, the Respondent failed to present sufficient expert testimony to establish proximate cause with respect to either the alleged negligence of Dr. Miller or the delay in seeing the Respondent on September 5, 2008. The Respondent offered nothing more than her expert's conclusory statements, which lacked medical explanations and were therefore "tenuous and hypothetical" in nature. Even when viewed in the light most favorable to the Respondent, the expert testimony did not meet the standards required for proving proximate cause in medical malpractice case.

The Respondent's expert effectively conceded the absence of proximate cause with regard to the alleged negligence of Dr. Miller. At trial, the expert reaffirmed the opinion stated in his deposition, which was that Dr. Miller's failure to order a non-stress test or biophysical profile on August 25, 2008, did not cause the baby's death. [Trial

Trans., p. 303.] Given that concession,[2] it was impossible for the Respondent to prove that Dr. Miller's acts or omissions proximately caused her claimed damages. Indeed, her expert's testimony supported only the opposite conclusion.

Even if the Respondent's expert had not conceded this point, he would have had no basis for attributing the baby's death to Dr. Miller's alleged negligence. The expert obviously could not say what the results would have been if the Respondent had undergone a non-stress test or biophysical profile on August 25, 2008. This means the expert could not say with any degree of probability – let alone reasonable certainty – that the tests would have revealed the need for immediate emergency treatments. The expert had no way of knowing whether the test results would have been anything but normal. After all, there is no evidence the Respondent had any complaints of decreased fetal movement or other problems during the time between her office visit on August 25 and her return to the office on September 5. It would be impossible for *anyone* to say what tests would have revealed during that time span, and the expert certainly did not give any opinion on this issue that satisfied the "most probably" standard.

Any argument for the existence of proximate cause with regard to Dr. Miller's alleged negligence would necessarily rely on speculation. No one can know what a non-stress test and/or biophysical profile conducted between August 25 and September 4 would have revealed. Thus, the Respondent can only claim those tests *might* have produced abnormal results, and those results *might* have alerted a reasonable and prudent physician to the need for immediate action such as an emergency C-section. The problem with that assertion, of course, is that the tests also might *not* have generated any

[2] The Respondent's other medical expert, Dr. Edward Karotkin, did not express any opinions one way or the other regarding Dr. Miller's treatment of the Respondent.

concerning results. For all the evidence shows, a non-stress test and/or biophysical profile conducted on August 25 would have come back perfectly normal. Absent expert testimony that tests performed on that day most probably would have shown the types of abnormal results that would have prompted immediate action, there is no basis for a finding of proximate cause under South Carolina law.[3]

The jury could not have properly based its verdict against the Practice on the treatment Dr. Miller provided to the Respondent. Even assuming Dr. Miller should have ordered a non-stress test and bio-physical profile on August 25, 2008, there is no evidence that the failure to perform those tests caused the baby's death. The record gave the jury no basis for concluding that not doing the tests on that date resulted in the death or even made it more likely. No one knows what, if anything, the tests would have revealed, and the notion that the results would have served as a warning sign to the doctors is pure speculation. Therefore, the expert testimony regarding Dr. Miller provides no support for the verdict against the Practice.

Similarly, any attempt to justify the verdict based on the "waiting time" allegations must fail. The gist of the Respondent's argument on this issue is the following: If a medical professional had seen her sooner on September 5, 2008, the tests would have been performed earlier and the doctor would have sent her to the hospital in time for an emergency C-section before the baby died. While this assertion might have

[3] This discussion demonstrates why the expert's attempts to say Dr. Miller "contributed to" the baby's death were inadequate to establish proximate cause. For one thing, the expert backtracked from those statements and returned to his original opinion stated in his deposition. But even if he had not, the expert's "contributed to" statements relied on speculation about what earlier tests might have shown. The expert never said such tests most probably would have produced alarming or even abnormal results, and that omission was fatal for purposes of establishing proximate cause.

some surface-level appeal, it cannot withstand more serious scrutiny. Just like the arguments based on the allegations against Dr. Miller, this position, at its most basic level, relies on speculation.

The Respondent arrived at the Practice's office around 8:40 am on September 5, 2008. She met with a nurse practitioner roughly one hour later and underwent a non-stress test a few minutes after that. There is no indication any significant delay occurred between the conclusion of that non-stress test and the commencement of the bio-physical profile. Thus, the "delay" in question involves the 70-80 minutes between the time the Respondent signed in and the start of the non-stress test. This is where the speculation inherent in the Respondent's position reveals itself.

The evidence shows the results of the actual non-stress test and bio-physical profile that took place between 10:00 am and 10:50 am on September 5, 2008. The evidence does not, of course, reveal what the results would have been had those tests occurred at 8:40 am when the Respondent first arrived. The Respondent apparently *assumes* earlier tests would have produced the same results, but there is no evidence to support that assumption. Neither of her medical experts stated what the results of earlier tests would have been. Like the Respondent, those experts appear merely to have assumed such tests would have generated similar results. However, neither of them gave any basis for that assumption, and neither actually expressed an opinion that earlier tests would most probably have revealed a problem. In other words, the experts operated on a premise that the baby's condition at 8:40 am would have been the same as its condition two hours later, even though they gave the jury no scientific or medical explanation for using that premise. *See Young v. Tide Craft, Inc.*, 270 S.C. 453, 469, 242 S.E.2d 671,

679 (1978) ("However complex or esoteric the specialized knowledge the expert draws upon, he must show that in formulating his opinion, he has taken into consideration the material facts of the case being tried ...").

Although they never said so directly, the Respondent's medical experts based their opinions on an assumption that the baby was already in distress by the time the Respondent arrived at the office. Such an assumption was necessary for the experts to conclude that earlier tests would have revealed a need for an emergency C-section. If the baby's condition was not the same at 8:40 am (*i.e.* if the baby was not already in distress), any tests conducted at that time would have yielded different results, which might not have warranted an immediate intervention. In that scenario, the experts' "waiting time" opinions would fail because the earlier tests would not have resulted in a need for the Respondent to go straight to the hospital.

This demonstrates the problem with the Respondent's "waiting time" allegations. To this day, no one knows how, why or even exactly when the baby died. The record contains some speculation as to the cause of death, but none of the experts on either side offered an actual opinion on that question. Indeed, all of the medical experts admitted they could not determine the cause of death. The absence of a cause of death is crucial because it prevents any showing of a causal nexus between the time the tests were conducted on September 5 and the baby's death. Without knowing *why* the death occurred, there is no legitimate basis for concluding that earlier medical action would have prevented it. *See Young*, 270 S.C. at 468, 242 S.E.2d 678 ("The probative value of expert testimony stands or falls upon an evidentiary showing of the facts upon which the opinion is, or must logically be, predicated.")

The Respondent's theory of liability (as presented by her medical experts) relies on the premise that the decline in the baby's condition had already reached a critical point when she arrived at the doctor's office. In other words, the Respondent believes the need for immediate action already existed, and this made the delay in performing the tests fatal. Yet, nothing in record shows that belief to be anything more than an assumption. Because no one knows what caused the death, it is impossible to say what condition the baby was in when the Respondent first arrived at the office. While it is possible the baby's condition was already worrisome by that time, it is equally possible the baby was safe. In the latter scenario, the baby's condition could have deteriorated sharply in the time between her arrival at the office and the running of the tests. There is simply no way to determine what actually happened to the baby during that time without first knowing the cause of death. And because the experts could not explain to the jury why the baby died, the jury had nothing other than speculation upon which to base a conclusion that the delay in running the tests proximately caused the death.

The Respondent's medical experts attempted to maneuver around this problem by claiming the baby's death was "foreseeable" or "predictable" by the early morning hours of September 5, 2008. There were at least two problems with that approach, however. First, that opinion still relies upon the unwarranted assumption that the baby was already in danger when the Respondent first arrived at the doctor's office. As previously discussed, the record does not contain any medical evidence to support that assumption. Second, the experts could not explain *why* the death was predictable or foreseeable. One of the experts stated that mothers with chronic hypertension require extra monitoring during prenatal care due to the potential for complications, but he did not go any further

with his testimony. The expert did not give any specific opinions about what extra monitoring would have found in the Respondent's case. Nor could he, as the baby's condition in the days – and even the hours – preceding the death remain a mystery. Thus, the experts' statements that the death was predictable were also based on conjecture, not medical science.

Another unsupported assumption also underlies the Respondent's "waiting time" allegations. The experts claimed that if the Respondent had gone to the hospital sooner, an emergency C-section would have saved the baby. Yet, the experts could not possibly express that opinion with any degree of certainty without knowing why the baby died in the first place. The experts never stated that any one potential cause of death was more likely than others. This means they failed to rule out causes of death that an emergency C-section could not have prevented. The experts simply did not address that issue in their testimony. As a result, the experts provided no medical basis for their belief that a C-section, if performed sooner, would have prevented the death. Instead, the experts relied on their subjective beliefs and supposition. Neither of which could sufficiently establish proximate cause under South Carolina law.

Under a certain set of circumstances, it is possible that earlier testing and an emergency C-section might have saved the baby. The problem for the Respondent is that her experts failed to prove those circumstances existed in this case. This could just as easily have been a situation in which no testing or emergency procedures could have prevented the tragic outcome. Because the experts could not determine how or why the baby died, they could not possibly say that the delay in testing "most probably" caused the death. Even if the experts used that phrase, the opinion would be based on nothing

more than speculation. Therefore, the opinions were insufficient to prove proximate cause. *See David v. McLeod Reg. Med. Center*, 367 S.C. 242, 249, 626 S.E.2d 1, 4 (2006) ("In South Carolina, medical malpractice actions require a greater showing than generic allegations and conjecture.").

Furthermore, part of the Respondent's "waiting time" allegations necessarily implicates the actions of Drs. Hilton and Benson, whom the jury vindicated. Those doctors played no role in determining when the Respondent first saw the nurse practitioner on September 5, 2008. However, as soon as Dr. Hilton took over the care a few minutes into the biophysical profile, all of the timing decisions were hers. Dr. Hilton was responsible for when she told the Respondent to go to Labor and Delivery at the hospital. After the Respondent left the office, Dr. Benson assumed control of her care, and he was responsible for treating her at the hospital.[4] In other words, the only thing not attributable to Drs. Hilton and Benson was the waiting time between the Respondent's arrival at the office and the start of the non-stress test. Because the jury found in favor of Drs. Hilton and Benson, the *only* possible allegation remaining for the Respondent involved that initial waiting time. Any allegations of events or decisions following the start of the non-stress test must fail as a result of the defense verdicts in favor of Drs. Hilton and Benson.

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[4] Here, it should be noted that the Respondent claimed she was kept waiting for a lengthy period of time while trying to check in at the hospital. There was no evidence that the check-in clerk at the hospital was an agent or employee of the Practice or that Dr. Benson had any ability or right to control how that person did her job. Thus, to the extent a delay in checking into the hospital caused the Respondent's damages, the Practice could not legally be liable for that delay.

(4) Analogous Case Law

There do not appear to be any South Carolina authorities directly on-point, but analogous decisions by this Court and the Supreme Court are in line with the Practice's positions on appeal. These cases demonstrate that it takes more than speculation and guesswork to establish proximate cause, even when the conjecture comes via medical experts. Rather, the plaintiff must be able to demonstrate a real and substantial causal connection between the alleged negligence and the claimed damages. Consequently, these cases support the Practice's contention that this Court should reverse the verdict in favor of the Respondent.

In *Carver v. Medical Soc. of South Carolina*,[5] the plaintiff suffered a burn during a surgical procedure. There was some evidence indicating that the burn resulted from electrical arcing due to the use of too much antibiotic solution. The plaintiff failed to present any expert testimony to establish proximate cause, relying instead on the obvious nature of the injury. The trial court granted judgment as a matter of law to the defendant, and this Court affirmed. The Court explained: "While the injury is obvious, its origin is not. As we view the matter, the burn could have possibly resulted from a number of causes including a failure of one of the fail-safe devices on the machine." 286 S.C. at 350-51, 334 S.E.2d at 127. Because there was no expert testimony identifying the defendant's negligence as the most probable cause of the burn, judgment for the defendant was appropriate.

Although the Respondent (unlike the plaintiff in *Carver*) did present medical experts at trial, their testimony did not sufficiently address the causes of the claimed

[5] 286 S.C. 347, 334 S.E.2d 125 (Ct. App. 1985)

damages. The experts could not say how or why the baby died, let alone specifically link the death to any conduct by the Practice. At the end of the trial, the origin of the Respondent's claimed injury (*i.e.* the baby's death) was still unclear. Under the reasoning of *Carver*, therefore, the Practice was entitled to judgment as a matter of law, the trial court erred in failing to grant that relief.

The Supreme Court reached a similar result in *Hoard v. Roper Hosp., Inc.*, 387 S.C. 539, 694 S.E.2d 1 (2010). There, the plaintiffs' baby was born with respiratory distress that required the insertion of an umbilical vein catheter ("UVM"). The insertion was performed poorly, a fact that the defendant radiologist allegedly failed to notice or report when viewing the x-rays. Another doctor later reviewed the radiologist's report and decided not to move the UVM. The baby suffered cardiac arrest, likely as a result of the misplaced UVM. The second doctor and the hospital settled with the plaintiffs, but the radiologist moved for summary judgment, contending there was no evidence of proximate cause. The trial court agreed and granted summary judgment to the radiologist. This Court reversed that decision, but the Supreme Court granted a writ of certiorari and reinstated the summary judgment.

Although there was expert testimony stating that the misplaced UVM most probably caused the baby's cardiac arrest and subsequent injuries, it did not specifically link the radiologist to those injuries. In addition, the evidence demonstrated that the second doctor knew the standard of care, recognized that the UVM was misplaced, and made his own professional judgment not to move it. The Supreme Court concluded this record provided a sufficient basis for summary judgment.

The plaintiffs' theory in *Hoard* was similar to the Respondent's allegations against Dr. Miller in this case. Just as the plaintiffs in *Hoard* alleged the radiologist failed to note the misplaced UVM, which eventually led to the cardiac arrest, the Respondent claims Dr. Miller failed to perform tests that might have revealed a problem ten days before the baby's death. Also like the plaintiffs in *Hoard*, however, the Respondent failed to present expert testimony to establish a specific causal link between Dr. Miller's alleged negligence and the claimed injuries. Thus, while the facts of the two cases are different, they are sufficiently analogous to make the Supreme Court's reasoning in *Hoard* applicable here.

Another analogous case is *Guffey v. Columbia/Colleton Reg. Hosp.*, 364 S.C. 158, 612 S.E.2d 695 (2005). There, the plaintiff's decedent died from a heart attack that occurred roughly one day after a doctor discharged him from the emergency room, where he had gone complaining of chest pain. The ER doctor testified that he told the decedent he could go home, but he should call his cardiologist the next morning. The plaintiff, who was with the decedent at the ER, denied hearing the doctor give that instruction. In addition, the discharge instruction sheet from the hospital only told the decedent to call his primary care physician if his condition had not improved after two days. The plaintiff alleged the defendant was negligent for failing to diagnose unstable angina, which would have warranted admission to the hospital. At trial, the defendant moved for a directed verdict, arguing that even if there was a breach of the standard of care, there was no evidence of proximate cause. The trial court granted that motion, and the plaintiff appealed.

The Supreme Court affirmed. Explaining its decision, the Court stated: "Because there is no evidence the conflicting discharge instructions proximately caused Decedent's death, the trial judge properly granted a directed verdict on this allegation of negligence."[6] 364 S.C. at 164, 612 S.E.2d at 697. The Court also noted that the record did not contain any expert testimony explaining why the decedent's fatal heart attack would have been prevented if he had seen his cardiologist the next morning. *Id.* This lack of expert evidence entitled the defendant to a directed verdict as to that theory of negligence.

The same lack of sufficient evidence exists in the present case. The Respondent's medical experts attempted to link the failure to run tests prior to September 5, 2008, and the wait time on that date to the baby's death, but they could not do so. The experts never explained how those alleged specifications of negligence caused the death, nor could they. The reason for the death was unknown, which meant there was no way the experts could say with any degree of certainty what caused or contributed to the death. The "opinions" the experts offered were purely speculative, and they did not meet the standards required under South Carolina law. Thus, the basis for the directed verdict in *Guffey* also exists here.

While none of these cases are exactly on-point, all of them are sufficiently analogous to support the Practice's position on appeal. All of the cases stand for the proposition that without expert testimony specifically explaining why and how the

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[6] The trial judge granted a directed verdict as to the allegation of negligence based on the discharge instructions, but sent the case to the jury on other specifications of negligence. One of the plaintiff's arguments on appeal was that the specifications of negligence could not be separated in that fashion for purposes of legal rulings, but the Supreme Court summarily rejected that assertion, citing previous authorities to the contrary. 364 S.C. at 163, 612 S.E.2d at 697, n. 3.

alleged negligence proximately caused the claimed injuries, a medical malpractice action must fail. As the Supreme Court noted in *Hoard*, a plaintiff in a medical malpractice case must establish a "significant causal link between the alleged negligence and the plaintiff's injuries, rather than a tenuous and hypothetical connection." 387 S.C. at 547, 694 S.E.2d at 5. The cases discussed in this section all demonstrate that point, as does the case currently at bar.

III. The Practice was entitled to judgment as a matter of law.

The jury flatly rejected all of the Respondent's claims based on the alleged negligence of Dr. Hilton and Dr. Benson (the physicians who treated the Respondent on the day of the baby's death). Although the Respondent and her experts focused almost all of their efforts at trial on the acts and omissions of Drs. Hilton and Benson, the jury concluded those doctors did not commit any malpractice. Those defense verdicts automatically relieved the Practice of any liability based on the Respondent's allegations against Drs. Hilton and Benson. For the verdict against the Practice to stand, therefore, the record must contain evidence that negligent acts or omissions by some other agent or employee of the Practice proximately caused the baby's death. As previously discussed, no such evidence exists.

Viewing the record in the light most favorable to the Respondent, there are expert opinions that could arguably show breaches of the standard of care by employees other than Drs. Hilton and Benson. However, there are no expert opinions establishing a causal link between any such breaches and the baby's death. The Respondent's experts never really even attempted to make that connection. This is why the verdict against the Practice cannot stand.

Regardless of what language the Respondent's experts used at trial, the fact remains that they could do no more than speculate about whether the baby would have survived had the alleged breaches not occurred. There was no expert testimony about what a non-stress test or biophysical profile would have shown if they had been performed on August 25, 2008. Thus, it is impossible for anyone to say that conducting those tests "most probably" would have prevented the death. For all the record shows, tests conducted on that date could have been completely normal, which would not have prompted any emergency action. Indeed, the experts never said alarming test results would have been any more likely than normal ones. Accordingly, the Respondent failed to prove a causal nexus between the alleged negligence of Dr. Miller on August 25, 2008, and the baby's death.

Similarly, there is no evidence that the amount of time the Respondent waited before the non-stress test on September 5, 2008, caused, or even contributed to, the baby's death. As the Respondent's own experts admitted, the cause of the baby's death remains a mystery. This means the experts could not possibly say the baby most probably would have survived if the Respondent had gotten to the hospital sooner. Any such opinion rests on an assumption that an emergency C-section at the hospital would have prevented the death, and there is simply no medical evidence in the record to support that conclusion. An emergency C-section *might* have saved the baby's life, but it also might *not* have done so. The evidence does not – and cannot – make either scenario more likely than the other. Without knowing the actual cause of death, there is no way to say a certain course of action most probably would have prevented it. Consequently, there was no basis for the Respondent's experts to say that the amount of time the

Respondent waited in the office before having a non-stress test proximately caused her damages. The experts could opine that the Respondent's wait was too long, but not that the wait led to the baby's death.

In short, the Respondent failed to prove a negligence claim against the Practice. Even if allegations against employees other than Drs. Hilton and Benson are considered, the record does not support the verdict against the Practice. The expert testimony failed to establish or support any causal nexus between those allegations and the death of the baby. Therefore, the trial court erred in failing to grant the Practice judgment as a matter of law. This Court should reverse the verdict against the Practice and remand for entry of judgment in the Practice's favor.

CONCLUSION

The death of the Respondent's baby was undeniably tragic, but the record does not provide a sufficient legal basis to hold the Practice liable for it. The defense verdicts in favor of Drs. Hilton and Benson eliminated any possibility of a verdict against the Practice based on the alleged acts and omissions of those doctors. In addition, the Respondent failed to present expert testimony to prove probable cause with regard to the claimed negligence of employees of the Practice other than Drs. Hilton and Benson. The Respondent's experts offered only speculation and opinions that were based on nothing more than unsupported assumptions. That was not enough to create a jury issue as to the malpractice claim against the Practice, and the Practice was entitled to judgment as a matter of law.

For these reasons, judgment in favor of the Practice was warranted, and the trial court erred in denying the Practice's motions for directed verdict and JNOV. This Court

should now reverse the verdict against the Practice and remand with instructions to enter judgment in the Practice's favor.

Respectfully submitted,

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

Steven H. John, Circuit Court Judge

Case No.: 2011-CP-46-00683

Samantha Jamison, as Personal Representative of the Estate of Jayden Joenelle Jamison-Barber, deceased.....Respondent,

v.

Ansley L. Hilton, MD, individually and as agent, servant or employee of Rock Hill Gynecological and Obstetrical Associates, PA; Christopher B. Benson, MD, as agent, servant or employee of Rock Hill Gynecological and Obstetrical Associates, PA; and Rock Hill Gynecological and Obstetrical Associates, PA, Defendants,

Of whom,

Rock Hill Gynecological and Obstetrical Associates, PA, is the.....Appellant.

DESIGNATION OF MATTER TO BE INCLUDED IN RECORD ON APPEAL

The Appellant designates the following materials to be included in the Record on Appeal with respect to the Initial Appellant's Brief:

1. Summons and Complaint;
2. Answer;
3. Trial Transcript, pp. 61-142, 150-185, 268-278, 287-308, 324-340, 354-445, 450-464, 479-690, 762-806, 864-866, 887-915, 958-968;
4. Rule 59(e) Motion and supporting memorandum;

5. Order (July 15, 2013);
6. Notice of Appeal.

I certify that these designations do not include any materials irrelevant to the issues on appeal.

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January 2, 2014

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PROOF OF SERVICE

The undersigned, an attorney in this matter for the Appellant, certifies that I have this **2nd day of January, 2014**, served copies of the **Initial Appellant's Brief** and **Designation of Matter to be Included in Record on Appeal** upon counsel of record for the Respondent by causing them to be deposited in the United States mail with sufficient postage affixed, addressed to: D. Bradley Jordan, Esq.; Jordan Law Firm; P.O. Box 11785; Rock Hill, SC 29731; and James W. Boyd, Esq.; P.O. Box 36425; Rock Hill, SC 29732.

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