STATE OF SOUTH CAROLINA
In the Court of Appeals

Appeal from Florence County
Court of Common Pleas

Michael Nettles, Circuit Court Judge

C.A. No. 2013-CP-21-00587
App. No. 2015-001237

Genesie Fulton, individually, and as Next Friend of Bryson F., a minor,

Appellants,

v.

L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN,

Respondents.

INITIAL BRIEF OF RESPONDENTS L. WILLIAM GOLDSTEIN, M.D., INDIVIDUALLY AND D/B/A L. WILLIAM GOLDSTEIN OB-GYN

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STATEMENT OF THE ISSUES ON APPEAL

Respondents would restate the issues on appeal as:

I. Did the Trial Court properly charge the jury on the obstetrical emergency statute, S.C. Code Ann. § 15-32-230, where the Plaintiffs allege medical malpractice by the Defendant Obstetrician in delivering Plaintiff Infant when he presented with shoulder dystocia and:

   A. The Plaintiff conceded that the presentation of shoulder dystocia constituted "a genuine emergency situation;"

   B. The Plaintiff conceded that the Infant was "in immediate threat of death" or "in immediate threat of serious bodily injury;" and

   C. There was disputed evidence that the Infant's condition was "not medically stable."

II. Did the Trial Court properly charge the jury on the definition of gross negligence?

STATEMENT OF THE CASE

This is a medical malpractice action arising out of the labor and delivery of a baby boy, Bryson F. (hereinafter referred to as Infant) on August 20, 2009. His mother, Genesie Fulton (hereinafter referred to as Patient or Mother), brought this action in her individual capacity and on behalf of her minor son, seeking damages for a permanent brachial plexus nerve injury that the Infant suffered during delivery. She filed a summons and complaint on February 28, 2013, alleging that her Obstetrician, Dr. William Goldstein and his practice (hereinafter referred to as Dr. Goldstein or the Obstetrician) failed to properly manage and resolve a condition of shoulder dystocia which occurred during his delivery. [ROA ___; Complaint.] Dr. Goldstein filed an answer, denying the allegations and asserting various defenses, including the limitation on liability found in the Emergency Medical Obstetrical Care Exception found in S.C. Code Ann. §15-32-230. [ROA ___; Answer, April 26, 2013.] An amended complaint was filed on **

An amended complaint [improperly captioned second amended complaint] was filed on April 30, 2015. [ROA ___; Amd. Complaint.] An Answer to the amended complaint was filed on May 4, 2015. [ROA ___; Answer.]

The case came to trial before the Honorable Michael G. Nettles, and a jury in the Florence County Court of Common Pleas on May 4-8, 2015. The Trial Court charged the jury on the Emergency Medical Obstetrical Care Exception, §15-32-230, [ROA ___; Tr. 1269:8-16], and presented a verdict form to the jury with special interrogatories. The jury returned a verdict for Dr. Goldstein, finding as to the Obstetrical Medical Emergency Exception, that "the facts of this care arise out of a genuine emergency situation where the patient is not stable and there is an immediate threat of death." Having so found that

the exception applied, the jury was instructed by the charge and the verdict form that the plaintiff was required to prove gross negligence. The jury found that the plaintiff "has not proved that the defendant breached the standard of care." [ROA ___; Verdict.]

The Patient filed a motion for a new trial on May 15, 2015. [ROA ___; Motion.] The Trial Court issued its order on May 19, 2015, denying the motion. [ROA ___; Order.] The Patient served a Notice of Appeal on June 8, 2015.

STATEMENT OF THE FACTS

Medical Evidence of the Obstetrical Emergency during Labor and Delivery

The Patient Mother was admitted for scheduled inducement of labor on August 20, 2009 at 36 weeks gestation. Dr. Goldstein artificially ruptured the membranes at 7:18 am and the labor proceeded uneventfully until 1:15 pm when the medical staff observed variables in the fetal heart rate. [ROA ___; Tr. 860 – Nurse Collins.] The Infant had reached plus 3 station and when the heart rate dipped to the 60s, Dr. Goldstein opted to use a vacuum (instead of forceps) to get the baby past the perineum. [ROA ___; Tr. 1005:15 – Dr. Salley.] The head was delivered after two pulls, but then at 1:44 p.m., Dr. Goldstein recognized that they were facing an emergency of shoulder dystocia. [ROA ___; Tr. 659.]

"[T]he definition of shoulder dystocia is when the head comes out, so the fetal head is out and the shoulder gets stuck under the pubic bone." [ROA ___; Tr. 173: 21-24.] Shoulder dystocia is an unpredictable and unpreventable risk to any pregnancy. [ROA ___, ___; Tr. 213, 223.]

Dr. Goldstein and the nurses immediately took the appropriate measures to address this medical emergency. The nurses performed a McRoberts maneuver by

hyperflexing the Mother's legs and abducting her thighs to change her position and began applying suprapubic pressure. [ROA ___; Tr. 662-63.] Dr. Goldstein performed first one, then a second, episiotomy to make room for him to reach in to guide the baby's shoulders. [ROA ___; Tr. 663, 668.] Meanwhile, one of the first things that Dr. Goldstein had done when he recognized the emergency was to call in another obstetrician. [ROA ___; Tr. 669.] Dr. Coker arrived within three minutes, he assessed the patient and took over applying the suprapubic pressure, the shoulders delivered, and the baby was born at 1:49pm – within five minutes of the shoulder dystocia being recognized. [ROA ___; Tr. 659, 668.]

During this process, Dr. Goldstein found that the nuchal cord was around the baby's neck and he successfully reduced the cord over the infant's head. [ROA ___; Tr. 674:12-13.] The Infant was hypotonic ("floppy") on delivery and intubated by the pediatric staff. [ROA ___; Tr. 680. ROA ___; Tr. 890. ROA ___; Tr. 943-44.] The Infant's APGAR at one minute was one, after five minutes it was four, it was five at 10 minutes, and seven at 15 minutes. [ROA ___; Tr. 680.] Initial blood tests of the cord blood showed that the Infant had a poor pH at 7.19. [ROA ___; Tr. 676.] Fortunately, the Infant quickly responded to the care and treatment of the pediatric staff in attendance and ultimately showed no signs of any brain injury. [ROA ___,___; Tr. 944, 214.] However, the Infant did suffer permanent brachial plexus nerve damage which the Patient alleges was caused by Dr. Goldstein using excessive traction delivering the shoulders.

Expert Opinions on the Standard of Care

Plaintiff's obstetrical expert, Dr. Gomez-Carrion, opined that Dr. Goldstein acted appropriately, when confronted with the medical emergency, by ordering McRoberts and suprapubic pressure. [ROA ___; Tr. 214.] She also opined that Dr. Goldstein acted appropriately and reasonably, when the suprapubic pressure and McRoberts were initially unsuccessful, by trying to insert his hand into the vagina and rotate the baby. [ROA ___; Tr. 214-15.] Dr. Gomez-Carrion agreed that "you can have a permanent brachial plexus injury and it does not always mean that the doctor did something wrong." [ROA ___; Tr. 218:1-4.] However, she was of the opinion that Dr. Goldstein caused the permanent injury to the Infant's brachial plexus nerve by using "excessive" traction to resolve the shoulder dystocia - even though she could not quantify how much traction was used. [ROA ___; Tr. 203. ROA ___; Tr. 218: 5-12.] In fact, she acknowledged that "there is no way to measure traction" and "nobody can say exactly or to specify how much traction was used." [ROA ___; Tr. 219:1-3. ROA ___; Tr. 218:11-12.] In contrast, the defense expert pediatric neurologist, Dr. Jacobson, opined that the Infant's brachial plexus injury did not result from excessive traction by Dr. Goldstein. [ROA ___; Tr. 941.]

Evidence of the Imminent Danger to the Infant

All of the medical expert opinion evidence establishes that time was of the essence in delivering the Infant because it was only a matter of matter of minutes before the Infant would have suffered brain damage or died. Dr. Goldstein explained the urgency of delivering the Infant as quickly as possible because if a baby stays in the birth

canal for a prolonged period of time, it can suffer brain damage due to lack of oxygen, or even die. [ROA ___; Tr. 687:1-10.]

Plaintiff's own obstetrical expert Dr. Gomez-Carrion testified that shoulder dystocia is an emergency situation with a risk of fetal death, and she agreed that: "And if a baby is not timely delivered in the face of shoulder dystocia, a medical emergency, the baby can die." [ROA ___; Tr. 213:10-13.] She testified that timing is critical because according to the obstetrical literature, an obstetrician has only six or seven minutes to safely get a baby out or there is a risk of brain damage or even death. [ROA ___; Tr.213:16-17.] Fortunately, Dr. Goldstein was able to get the Infant delivered within five minutes and the pediatric staff successfully resuscitated the Infant.

ARGUMENT

Jury Instructions and Appellate Review

When instructing the jury, the trial court is required to charge the jury the current and correct principles of law that apply to the issues raised in the pleadings and developed by the evidence in support of those issues. *Clark v. Cantrell*, 339 S.C. 369, 389-90, 529 S.E.2d 528, 539 (2000).

"No party may assign as error the giving or the failure to give an instruction unless he objects thereto before the jury retires to consider its verdict, stating distinctly the matter to which he objects and the grounds for his objection." Rule 51, SCRCP. An issue is not preserved for appellate review where the objection was made at trial on different grounds. *State v. Smith*, 337 S.C. 27, 34, 522 S.E.2d 598, 601-02 (1999).

"An appellate court will not reverse the trial court's decision regarding jury instructions unless the trial court committed an abuse of discretion. An abuse of discretion occurs when the trial court's ruling is based on an error of law or is not supported by the evidence." *Cole v. Raut*, 378 S.C. 398, 404, 663 S.E.2d 30, 33 (2008) (citing *Clark v. Cantrell*, supra). On appellate review of challenged jury charges, the court construes the trial court's charge as a whole in light of the evidence and issues presented at trial. *Keaton ex rel. Foster v. Greenville Hosp. Sys.*, 334 S.C. 488, 497, 514 S.E.2d 570, 575 (1999). Even if some error is found in the trial court's jury charge, the judgment on the jury's verdict will not be reversed except upon a showing of prejudice. *Brown v. Stewart*, 348 S.C. 33, 53, 557 S.E.2d 676, 686 (Ct. App. 2001).

I. THE TRIAL COURT PROPERLY CHARGED THE JURY ON THE OBSTETRICAL MEDICAL EMERGENCY EXCEPTION AS PROVIDED IN §15-32-230.

Applicable Law – Limitation on Liability for Emergency Obstetrical Care

The South Carolina Noneconomic Damage Awards Act of 2005, S.C. Code Ann. § 15-32-230, provides:

> **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.

The limitation on liability is an affirmative defense and, as such, the defendant physician has the burden of proving that the limitation applied upon proof of which, the plaintiff patient bears the burden of proving gross negligence. *Strange v. S.C. Dept. of Highways & Pub. Transp.*, 314 S.C. 427, 430, 445 S.E.2d 439, 440 (1994) ("The burden of establishing a limitation upon liability or an exception to the waiver of immunity under the Tort Claims Act is upon the governmental entity asserting it as an affirmative defense."; *Niver v. S.C. Dep't of Highways & Pub. Transp.*, 302 S.C. 461, 463, 395 S.E.2d 728, 730 (Ct. App. 1990) (limitations on liability under Tort Claims Act are affirmative defenses); *James v. Lister*, 331 S.C. 277, 283, 500 S.E.2d 198, 201 (Ct. App. 1998) (holding that the limitation on liability for charitable organizations, section 33–55–210(A) constitutes an affirmative defense); *Stewart v. Richland Mem'l Hosp.*, 350 S.C. 589, 595, 567 S.E.2d 510, 513 (Ct. App. 2002) (governmental entity's burden to establish that the limitation on liability applied, and plaintiff's burden to establish gross negligence).

A. The Plaintiff conceded that the presentation of shoulder dystocia constituted "a genuine emergency situation."

Every obstetrical expert – both Plaintiffs' and Defendants' testified that shoulder dystocia is a medical emergency. [ROA ___, ___; Tr. 160:21, Tr. 213:7-9 – Dr. Gomez-Carrion. ROA ___; Tr. 446:23-24 – Dr. Resnick. ROA ___; Tr.782:17-20 – Dr. Gower. ROA ___; Tr. 1067:20 – Dr. Salley. ROA ___; Tr. 1127:8 - Dr. Hall.] The Patient Mother also testified that it was an emergency situation. [ROA ___; Tr. 145:4-6.] The Patient even expressly conceded that there was "a genuine emergency situation:"

> MR. RUFFIN: Well, it's not a matter of being a medical emergency, because we know it's a medical emergency. [ROA ___; Tr. 1114:21-22.]
>
> ***
>
> THE COURT: A genuine emergency situation. You concede that?
>
> MR. RUFFIN: Yes. Shoulder dystocia is a medical emergency. [ROA ___; Tr. 1115:12-15.]

B. The Plaintiff conceded that the Infant was "in immediate threat of death" or "in immediate threat of serious bodily injury."

The Plaintiff Patient argues on appeal that the Defendant Obstetrician "failed to present any evidence that any patient was in immediate threat of death or serious bodily injury." [Appellants' Brief, p. 11-12.] This argument is unfounded and should be rejected for several reasons: first, and foremost, the Patient conceded that there was an immediate threat of death or serious bodily injury; second, she did not raise this issue to the trial court; and third, there is ample evidence of the immediate threat of brain damage or death.

During the colloquy concerning the Emergency Obstetrical Care Exception, the Patient stated:

> THE COURT: Involving an immediate threat of death or serious bodily injury.
>
> MR. RUFFIN: The threat is there. If it had been seven, eight, nine minutes, that would have possibly become a reality. But the section 1, I believe it is, is applicable. We argue the exception to, a little bit further down, I can't quite remember exactly what sub-part it is, but it says A and B can be applied unless, and then it says, the patient is medically stable. [ROA ___; Tr. 1115:16-24.].

When counsel concedes a point in the trial court, the question cannot be raised in the appellate court. *Southern Ry. Co. v. Routh*, 161 S.C. 328, 159 S.E. 640, 642 (1931); *Gatewood v. Moses*, 39 S.C.L. 244, 246 (S.C. App. L. 1852) (a party will not be allowed to raise a ground on appeal that has been expressly waived in the circuit court.) Nor can a party change his arguments on appeal:

> Appellant's present argument is not preserved for consideration on appeal. Prior to the charge, appellant objected to instructing the jury on the statute, arguing there was no evidence as to his location at the time of the shooting. He did not claim, as he does now, that there is no requirement the trial judge instruct the jury on the unlawful possession statute or the charge constituted a comment on the facts in violation of the Constitution. Since he did not object at trial on the same grounds as raised on appeal, the issue is not preserved for review.

State v. Smith, 522 S.E.2d at 601; *Gatewood v. Moses*, id.

When the Plaintiff made her objection to the Emergency Obstetrical Care Exception statutory charge, she only noted one ground – the absence of evidence that the Infant was not medically stable:

> MR. RUFFIN: Your Honor, we take exception to their request for inclusion of the Obstetrical Emergency Statute. It is inapplicable as a matter of law to this case based on one of the exceptions included. They have offered zero testimony that [the Infant] was medically unstable in this case. [ROA ___; Tr. 1112:10-15. See also ROA ___; Tr. 1115.]

The Plaintiff also objected to the Emergency Obstetrical Care Exception on the verdict form on the "not medically stable" ground:

> I just want to make sure we are protected with our objection to the obstetrical emergency exception on the verdict form and we just believe that the not medically stable or medically stable is its own basis by which to avoid the obstetric medical emergency exception. [ROA ___; Tr. 1257:5-9]

Similar to *State v. Smith,* the Patient objected to a charge on the Obstetrical Emergency Care Exception arguing that there was no evidence that either patient was not medically stable. She did not claim, as she does now, that there was no evidence of an immediate threat. Since she did not object at trial on that ground, it is not preserved for review.

Third, but not least, the Patient's argument is not supported by the evidence of record. Patient argues that Dr. Goldstein "confirmed" that the Infant was delivered before there was any immediate risk or threat of brain damage. However, the transcript, as she cited, does not support any such "confirmation:"

> Q: It was. It was. I plead guilty, sir. Let me try to break it down. We heard you talk about risk of brain damage. All right? You're not claiming there was any imminent risk of brain damage that justified you in using too much traction, are you?
>
> A: No, I'm not implying that I used too much traction – [ROA ___; 754:18-23.]

This was not a concession that there no was immediate risk or threat of brain damage. This was a denial that he used too much traction, and when Dr. Goldstein completed his next answer, he clarified the threat: "-- but from the literature there's been episodes of hypoxic ischemic encephalopathy that occurred within two minutes of the head to shoulder interval." [ROA ___; Tr. 754:25-755:2.]

The Patient also cites to specific transcript pages/lines where defense expert, Dr. Gower, supposedly confirmed that the Infant was not in immediate risk or threat of death or brain damage. [Appellants' Brief, p. 12.] However, those transcript excerpts only

show the expert's opinion of whether the medical records show that Dr. Goldstein perceived there was a threat:

> Q: In fact, in this case was there ever in your opinion any indication that Dr. Goldstein feared for the baby's life?
>
> A: No, I didn't have any indication of that. [ROA ___; Tr. 842:16-19.]
>
> ***
>
> Q: But I thought you just told me that you didn't see any indication that Dr. Goldstein had any concerns of those. Is that do you think he should have and didn't?
>
> A: Well, I mean, I would have had to know what he was thinking at the time and so I -- he wouldn't have -- that would have been maybe his thought process, but I don't know how I would know, so I guess my assumption is that we're always thinking about that.
>
> Q: Okay. So, you're just assuming he may have had that. You didn't actually see anything in the ---
>
> A: Correct.
>
> Q: --- medical records or any documentation ---
>
> A: That's exactly right.
>
> Q: --- or deposition. Okay. So, there was nothing that you ever saw that indicated he was in fear of the baby's life or that there was an imminent risk of brain damage?
>
> A: No, I don't have indication of that. [ROA ___; Tr. 843:16- 844:7.]

The transcript shows that Dr. Gower actually acknowledged that the risk was a matter of only four to five minutes and that any obstetrician would be thinking about possible brain damage:

> Q: Well, and including your review of the records, et cetera, in this case, there was nothing there that occurred during this shoulder dystocia and the way it was managed that raised a concern to you that there was an imminent risk of brain damage.

> A: Well, you know, we're talking about four or five minutes to, to get the baby out and we're talking about umbilical cord compression and we know there is a time in that the baby is not getting adequate oxygen and your pH is going down and your oxygen level's going down, your carbon dioxide is going up and so you have that, so yeah, it would be incumbent on any of us in that situation to begin at some point to be thinking about how is this, how's this baby doing as far as the blood flow to the brain. [ROA ___; Tr. 843:1-15.]

Another defense expert, Dr. Mark Salley, also testified about the risk of brain damage:

> ...the number one risk, again, is oxygen deprivation to the baby where the baby doesn't get enough oxygen and that creates injury to the baby's brain. I don't know if any of the jurors have seen a child with cerebral palsy, but that's one of the consequences of low oxygen, so that's always the most concerning problem when you have a baby that's stuck. [ROA ___; Tr. 1000:16-22.]

> During shoulder dystocia delivery, shoulder impaction and prolonged head to body delivery interval can lead to birth asphyxia and subsequent neonatal hypoxic ischemic encephalopathy, which is big words for saying brain damage for not enough oxygen. [ROA ___; Tr. 1021:7-11.]

Accordingly to reports, as testified by Dr. Salley, "permanent neurological injury can occur as soon as two minutes after shoulder impaction," [ROA ___; Tr. 1021:17-18.]

The Patient's basic argument appears to be that because the Infant was safely delivered within five minutes instead of pushing the limit at the seven-eight minutes critical danger zone there was no "immediate" threat. However, the standard for jury charges is: "If there is any evidence to support a jury charge, the trial judge should grant the request." *State v. Brown*, 362 S.C. 258, 262, 607 S.E.2d 93, 95 (Ct. App. 2004). As recounted above, there was abundant evidence of an immediate threat to support the Trial Court's decision to charge the Obstetrical Emergency Care Exception, §15-32-230.

C. There was evidence that the Infant was "not medically stable".

As discussed above, the Patient's objection – at trial – was the alleged lack of evidence that the Patient was "not medically stable." As a threshold matter, it is notable that our statute does not define medical stability, and the Patient did not request any jury charge to define the term.[1] Although there was ample testimony about the dire risks and Despite the Infant's perilous condition at birth, the crux of the Patient's argument is that

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[1] Several other states have enacted similar limitations on liability for emergency medical care. See, i.e. Ga. Code Ann. § 51-1-29.5 (West); Tex. Civ. Prac. & Rem. Code Ann. § 74.153 (West). However, those other statutes do not contain any comparable provision requiring proof that the patient was "not medically stable."

Medical stability is a concept found in workers compensation law in some jurisdictions, but it relates to the distinction between temporary v. permanent benefits. 82 Am. Jur. 2d *Workers' Compensation* § 363 ("Once a workers' compensation claimant is medically stable, he or she is no longer in the period of recovery, and the total temporary benefits cease.") Under this concept the Infant certainly would not be considered medically stable.

Perhaps the most relevant jurisprudence on the concept of medical stability can be found in the federal Anti-Dumping statute, EMTALA, 42 U.S.C. § 1395dd, where medical stability is a key element. The EMTALA requires that hospitals with emergency rooms provide limited stabilizing treatment to or an appropriate transfer of any patient that arrives with an emergency condition. The Act defines "to stabilize" as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual...." 42 U.S.C. § 1395dd(e)(3)(A). *Bryan v. Rectors & Visitors of Univ. of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996). It has been noted that the statutory definition does not correspond to a medical definition:

> EMTALA's definition of "stability" does not share the same meaning as the medical term "stable condition," which "indicates that a patient's disease process has not changed precipitously or significantly," Tabor's Cyclopedic Medical Dictionary 1861 (Clayton L. Thomas ed., 17th ed.1993); see also Mosby's Medical, Nursing, & Allied Health Dictionary 1474 (Kenneth N. Anderson et al. eds., 4th ed.1994) (defining "stable condition" as "a state of health in which the prognosis indicates little if any immediate change").

St. Anthony Hosp. v. U.S. Dep't of Health & Human Servs., 309 F.3d 680, 694 (10th Cir. 2002). It should be fair to say that neither the Mother nor the Infant were in any condition for transport during the delivery. There also should not be any dispute that the Infant's condition during delivery was changing minute to minute.

neither Dr. Goldstein nor his expert used the term "not medically stable." However, neither the statute nor basic medical malpractice precedent requires that experts use any "magic words."

For example, our Appellate Courts have held on a number of occasions that medical experts do not have to use the magic words "most probably" in offering causation opinions. See *Gamble v. Price*, 289 S.C. 538, 541, 347 S.E.2d 131, 132 (Ct. App. 1986) (discussion of precedents). The Court has also held that a medical expert does not have to use any "ritual incantation of certain magic words" to establish a breach of the standard of care. *Stallings v. Ratliff*, 292 S.C. 349, 353, 356 S.E.2d 414, 417 (Ct. App. 1987). Although neither Dr. Goldstein nor his expert witnesses specifically recited that the Infant was "not medically stable," their testimony and that of the other medical witnesses (as well as of the medical records) provide sufficient evidence to support the trial court's decision to charge the jury on the Emergency Obstetrical Care Exception.

Prime evidence of the Infant's perilous medical condition includes the fact, as noted above, that the nuchal cord was wrapped around his neck, which providentially Dr. Goldstein was able to remove during the delivery. On delivery, the Infant was hypotonic – "floppy"; he had a low pH of 7.19; and he had "very low" APGAR scores. Dr. Jacobson, the defense expert pediatric neurologist, testified that the initial APGAR of one means that the Infant's "tone was very low and it also signifies that the baby has had significant stress and significant hypoxy," [ROA ___; Tr. 943:24 – 944:2.] According to Dr. Salley, the Infant's first APGAR of one was "about as bad as it gets." [ROA ___; Tr.1021:1-2.]

On reply, the Patient elicited testimony from her expert, Dr. Hall, using the "magic words" that the Patient Mother and Child were both medically stable during the course of the management of the shoulder dystocia. [ROA ___; Tr. 1132.] While he testified that the pH of 7.19 was not terrible, Dr. Hall also testified that there were some variables of risks of brain damage during the four minutes immediately prior to delivery, including the cord wrapped around the neck. [ROA ___; Tr. 1134, 1131.] However, he insisted that the Infant resuscitated "quite well" with no signs of brain damage. [ROA ___; Tr. 1134:23.]

Patient argues paradoxically that while the Infant might have become medically unstable if enough time had passed, the Emergency Obstetrical Care Exception does not apply because the risk did not materialize. [ROA ___; Tr. 1116:-15-16.] However, the trial court wisely reflected that: "If I was in a spot where eight minutes might get cerebral palsy or dead, I would consider that to be an emergency." [ROA ___; Tr. 1116:16-18.]

While the statute speaks of "a genuine emergency," "immediate threat" and "not medically stable" as seemingly separate elements, the medical evidence is not quite so distinct. And, while it is apparent from the trial testimony that there was a dispute between the different experts as to implications of the Infant's medical condition at the time of delivery, there was sufficient evidence presented for the jury to decide, on proper instructions from the Trial Court, whether the Exception applied.

II. THE TRIAL COURT CHARGED THE JURY ON THE CORRECT LAW DEFINING GROSS NEGLIGENCE.

Since the Emergency Medical and Obstetrical Care Exception statute requires that the plaintiff prove gross negligence, it was incumbent on the Trial Court to charge the jury on what that term means. During the charge conference, Plaintiff Patient raised this point:

> MR. RUFFIN: And, Your Honor, are you including a charge that defines gross negligence and, if so, I was wondering how it is defined?
>
> THE COURT: It says, "Gross negligence is the failure to exercise even the slightest care, while negligence is the failure to exercise due care. That's about as simple as you can get.
>
> MR. RUFFIN: Your Honor, I think there is another definition that I've found that says, it means, "The absence of care that is necessary under the circumstances." It says it's also been defined as. And that's found in Pack and Associates versus Marine Institute.
>
> THE COURT: There's also going to be some discussion about gross negligence and willfulness and the punitive damage charge, but as far as it relates to this, there's just going to be a short definition of what gross negligence is. [ROA ___; Tr. 1176:1-16.]

The Trial Court charged the jury on the definition of gross negligence as follows:

> In an action involving a medical malpractice claim arising out of care rendered in a genuine emergency situation in an obstetrical suite where the patient is not stable and there is a threat of death or serious bodily injury to the patient, no physician may be held liable unless it is proven that the physician was grossly negligent. Grossly negligent. Let me define what that is. Gross negligence is the failure to exercise even the slightest care while negligence is the failure to exercise due care. [ROA ___; Tr. 1269:8-16.]
>
> ***
>
> If the Obstetrical Medical Emergency Exception applies, Plaintiff must prove gross negligence, that the breach was more than carelessness, but a failure to exercise even a slight degree of care.
> [ROA ___; Tr. 1277:15-18]

Plaintiff noted the following objection to the jury charge as given:

> MR. RUFFIN: Your Honor, nothing other than what I said previously about the gross negligence. There are two or three definitions that are included and I think that just including the slight care one is the one most favorable to the Defendant and I think it would be more accurate to include the other definitions, as well. I think that's it. I mean, if we start, you know, we've already got our question about the verdict form ...
> [ROA ___; Tr. 1282:4-11.]

On the jury verdict form, the Trial Court included a definition of gross negligence in a footnote: "*If the Obstetrical Medical Emergency Exception applies the Plaintiff must prove gross negligence (that the breach was more than carelessness, but was a failure to exercise a slight degree of care)." [ROA ___; Verdict p. 1.] While the Plaintiff Patient made an objection to the footnote on the verdict form at trial, [ROA ___; Tr. 1216:5], she has not raised that issue on appeal.[2]

"This Court has defined gross negligence in a number of ways." *Hollins v. Richland Cty. Sch. Dist. One*, 310 S.C. 486, 490, 427 S.E.2d 654, 656 (1993).

> In *Anderson v. Ballenger*, 166 S.C. 44, 55, 164 S.E. 313, 317 (1932), we held that it was "**the failure to exercise slight care.**" In subsequent cases, it has been defined as "the intentional, conscious failure to do something which it is incumbent upon one to do or the doing of a thing intentionally that one ought not to do." *Richardson v. Hambright*, 296 S.C. 504, 506, 374 S.E.2d 296, 298 (1988) (Emphasis supplied). We have also stated that "[g]ross negligence is a relative term, and means **the absence of care that is necessary under the circumstances.**" *Hicks v. McCandlish*, 221 S.C. 410, 415, 70 S.E.2d 629 (1952) (Emphasis supplied).

Id. (emphasis added); *Clark v. S. Carolina Dep't of Pub. Safety*, 362 S.C. 377, 382, 608 S.E.2d 573, 576 (2005); *Pack v. Associated Marine Institutes, Inc.*, 362 S.C. 239, 245, 608 S.E.2d 134, 138 (Ct. App. 2004).

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[2] *See Maus v. Pickens Sentinel Co.*, 258 S.C. 6, 186 S.E.2d 809 (1972) (objection to jury charge is waived where it is not argued in brief).

The trial court did not refuse to charge on gross negligence. In fact, the trial court correctly charged that gross negligence "is the failure to exercise even the slightest care" as defined in many appellate opinions. The Patient seeks to reverse the jury's verdict and retry the case because the Trial Court declined to charge the additional/alternative language "the absence of care that is necessary under the circumstances." However, the Trial Court's refusal to charge the additional language does not amount to reversible error because the instruction given was correct and fairly covered the definition of gross negligence.

"It is not error to refuse a request to charge when the substance of the request is included in the general instructions." *Brown v. Stewart*, 557 S.E.2d at 686 (citing *Varnadore v. Nationwide Mut. Ins. Co.*, 289 S.C. 155, 160, 345 S.E.2d 711, 715 (1986)).

> When reviewing a jury charge for alleged error, an appellate court must consider the "charge as a whole in light of the evidence and issues presented at trial." *Keaton ex rel. Foster v. Greenville Hosp. Sys.*, 334 S.C. 488, 497, 514 S.E.2d 570, 575 (1999). "A jury charge is correct if '[w]hen the charge is read as a whole, it contains the correct definition and adequately covers the law.' " Id. at 496, 514 S.E.2d at 574 (quoting *State v. Johnson*, 315 S.C. 485, 487 n. 1, 445 S.E.2d 637, 638 n. 1 (1994)). A jury charge which is substantially correct and covers the law does not require reversal. Id. at 496–98, 514 S.E.2d at 575.

Stewart v. Richland Mem'l Hosp., 567 S.E.2d at 513; *Martin v. Columbia Elec. St. Ry., Light & Power Co.*, 84 S.C. 568, 66 S.E. 993, 994 (1910) (no error to refuse to read party's request to charge where point was covered in general instructions).

"The substance of the law is what must be instructed to the jury, not any particular verbiage." *Keaton ex rel. Foster v. Greenville Hosp. Sys.*, 514 S.E.2d at 574 (quoting *State v. Smith*, 315 S.C. 547, 554, 446 S.E.2d 411, 415 (1994)). Considering the trial court's jury charge as a whole, the gross negligence definition was free of error and the

absence of the requested additional language was not misleading in any prejudicial manner as to justify reversing the jury's verdict.

CONCLUSION

WHEREFORE, based on the foregoing, the Respondents respectfully submit that the trial court charged the jury as to the correct principles of law that apply based on the evidence adduced in support of the issues raised in the pleadings. The trial court properly charged the jury on the Emergency Obstetrical Care Exception, S.C. Code Ann. § 15-32-230, where the Patient conceded that the presentation of shoulder dystocia constituted a genuine emergency situation and that the Infant was in immediate threat of death or serious bodily injury, and there was evidence that the Infant's condition was not medically stable. The trial court also charged the jury a correct definition of gross negligence. Accordingly, the Court should affirm the jury's verdict in favor of the Respondents.

Respectfully submitted,

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