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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

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SC Court of Appeals

William H. Seals, Jr., Circuit Court Judge

Appellate Case No. 2016-001551

Christy Byrd, as Next Friend of Julia B., a minor, ... Appellant,

v.

McLeod Physician Associates II and Dr. John B. Browning, ... Respondents.

FINAL BRIEF OF APPELLANT

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STATEMENT OF ISSUES ON APPEAL

I. DID THE TRIAL COURT ERR BY NOT DETERMINING THE OBSTETRIC EMERGENCY AFFIRMATIVE DEFENSE FAILED AS A MATTER OF LAW?

STATEMENT OF THE CASE

This is a medical negligence case involving an injury sustained by minor Julia B. at birth on October 8, 2009. Christy Byrd brought this action as Next Friend of Julia, a Minor. Appellant alleges that McLeod Physician Associates, Inc. and its employee John B. Browning failed to properly manage and resolve a condition known as shoulder dystocia. Shoulder dystocia is a condition where during a head-first vaginal delivery the infant's shoulder becomes lodged behind the mother's pubic bone. Appellant alleges that instead of using gentle traction and properly performing the appropriate maneuvers to safely resolve the dystocia, Dr. Browning improperly used excessive force upon baby Julia's head sufficient to cause the nerves in Julia's neck to rupture. Julia now has permanent brachial plexus nerve damage, deformity, and deficiency in movement.

The Summons and Complaint were filed on March 12, 2013 and designated as Civil Action Number 2013-CP-21-00690. (R. pp. 12-17). On May 10, 2013, Defendants Dr. Browning and McLeod Physician Associates, Inc. answered with general denials and assertions of several affirmative defenses. (R. pp. 20-27). An amended Answer was filed on April 16, 2014, which added the solicitation of charitable funds act affirmative defense. (R. pp. 28-35). Both Defendants' answer and amended answer included as an affirmative defense the emergency obstetrical care exception found under S.C. Code Ann. § 15-32-230. (R. pp. 26 and 34).

The case first went to trial against Defendants in the Florence County Court of Common Pleas on September 22, 2015, ending in a mistrial. The case was retried before the Honorable Judge William H. Seals, Jr. beginning on Monday May 16, 2016 and ending on Friday, May 20, 2016. After Plaintiff rested her case Defendants moved for directed verdict. (R. p. 422, line 13).

The Court granted the motion for directed verdict to strike the punitive damages claim against McLeod Physicians Associates II, as it was determined to be a not-for-profit entity. All other grounds for directed verdict were denied. (R. p. 427 lines 7-10).

The Court held the charge conference on Thursday afternoon, with the judge stating it would be completed before the end of day with no new additions. (R. p. 786 lines 15-23). At the charge conference, S.C. Code Ann. § 15-32-230 was discussed as being an affirmative defense. (R. p. 797 lines 11-21, p. 801 lines 5-10). The charge conference ended with agreement on the jury charge. (R. p. 815 line 22 to 816 line 3). The following morning, Defendants for the first time argued S.C. Code Ann. §15-32-230 was not an affirmative defense. (R. p. 817 lines 16-19). The trial court noted on the record that the same counsel for Defendants in this case signed an appellate brief in another case still pending before this Court in which the same attorneys admitted the statute was an affirmative defense. (R. p. 872 lines 8-23, R. p. 925-944). The trial court quoted the language from defense counsel's appellate brief which stated the "limitation on liability is an affirmative defense and, as such, the defendant physician has the burden of proving that the limitation applies," and that an affirmative defense is a set of facts which "if proven by the defendant, defeats or mitigates the legal consequences of the defendant's otherwise negligent conduct." (R. p. 872 line 15 to 873 line 10). Ultimately, the trial court in this case was persuaded by the arguments set forth by defense counsel in the *Fulton* brief and ruled the obstetric emergency exception was in fact an affirmative defense. (R. p. 873 line 5 to 874 line 22).

At the close of their case, Defendants moved for directed verdict, arguing the obstetric emergency affirmative defense applied and that Plaintiff had failed to prove gross negligence. (R. p. 875 line 19 to 876 line 8). The trial court denied Defendants' motion. (R. p. 876 line 9). Plaintiff moved for directed verdict that the obstetric emergency affirmative defense did not apply to this

case as a matter of law. Plaintiff argued Defendants had not established two of the three necessary elements of the affirmative defense; the patient must be medically unstable, and the patient must be in immediate threat of death or serious harm. (R. p. 876 lines 10-21). The trial court denied Plaintiff's motion, and whether the affirmative defense applied was left for the jury to determine.

The jury began deliberations around approximately 3:08 PM Friday afternoon. (R. p. 904 line 25). At around 4:00 PM, the jury requested to see the birth video. (R. p. 905 lines14-20). At around 4:30, the jury requested to hear the definition of gross negligence again. (R. p. 908 line 21 to 909 line 8). The jury reached a verdict at around 6:09 PM. (R. p. 910 lines 16-21). The jury determined the defendants had established the obstetric emergency affirmative defense. (R. p. 912 lines 3-8) and that Dr. Browning was not grossly negligent. (R. p. 912 lines 9-11, R. p. 10).

Plaintiff filed a motion for a new trial absolute and or judgment notwithstanding the verdict on May 31, 2016. (R. pp. 36 to 48). Defendants filed a response on June 13, 2016. (R. pp. 49 to 57). The trial court entered its order denying Plaintiff's motion for new trial on July 11, 2016. (R. pp. 1 to 4). Appellant timely filed her notice of appeal on July 28, 2016. (R. p. 916). The transcript was completed January 3, 2017. Although the non-economic losses are indeterminate, Appellant's economist testified the total financial loss sustained by Julia was $969,208. (R. p. 271 lines 6-19).

STATEMENT OF FACTS

On October 8, 2009 Christy Byrd, a cosmetologist, and her husband David, an athletic director for Cheraw High School, headed to McLeod Hospital. High school sweet-hearts, the two were preparing for the arrival of their third little girl, Julia. (R. p. 77 line 22 to 78 line 12). As with their two prior deliveries, the entire family accompanied David and Christy to the hospital. (R. p. 79 line 1 to 80 line 20, 84 lines 3-13). This included Stacy Puett, who became the videographer of Julia's birth. *Id.* In her two previous pregnancies and deliveries, Christy had no complications. (R.

p. 80 line 21 to 82 line 12). Similarly, Christy had no complications during her pregnancy with Julia. Indeed, there was nothing particularly eventful about Christy's labor with Julia until the last forty-five seconds.

Labor progressed, and Dr. Browning entered the room and positioned himself between Christy's legs in preparation for delivery. Christy was told to start pushing. Christy and her husband explained that from the time Christy was told to start pushing she was never instructed to stop. (R. p. 87:2-8, 397 lines 9-19). Around this time, nurse Misty leaned over Christy and applied pressure to Christy's body. (R. p. 87 lines 14-20). Julia was born at 5:33 PM. (R. p. 470 lines 14-18). Julia had no movement of her right arm at birth. (R. p. 87 line 23 to 88 line 18). Dr. Browning explained this was "a stinger," meaning just a temporary loss of movement that would return. *Id.*

Julia's arm remains permanently impaired to date. She has been in treatment since she was three months old. (R. p. 96 lines 4-19). Her family has traveled across the country to receive tests and treatments for Julia. (R. p. 99 line 6 to 100 line 2, p. 101 lines 16-23). Surgery was performed by Dr. Ratner at Children's Healthcare of Atlanta. (R. p. 102 lines 19-24). To date, Julia still has a significant loss of function in her right arm that will never return. This prohibits her from doing ordinary tasks such as carrying a school lunch tray or cleaning herself properly. (R. p. 88 line 19 to 89 line 6, p. 104 line 22 to 105 line 10). Julia's right arm is shorter than her left, her shoulder is sloped, and her right arm lacks full mobility. *Id.* (R. p. 95 line 19 to 96 line 3).

Appellant presented evidence at trial that Julia's injury occurred when Dr. Browning mismanaged a condition known as shoulder dystocia. Dr. Pliskow, an OBGYN with over twenty-six years in the field, testified that Dr. Browning breached the standard of care first by failing to instruct the mother to stop pushing after shoulder dystocia was encountered. (R. p. 204 lines 12-22). An instruction to stop pushing is never heard in the video but continuous urging to push and

push harder can be heard. (*Id.* 221 line 13 to 222 line 6). Julia's parents confirmed what the video showed. (R. p. 87 lines 2-8, 397 lines 9-19). Continued pushing further impacts the infant's shoulder against the pubic bone, making the condition harder to resolve. (R. p. 204 lines 4-11).

The second breach in the standard of care was Dr. Browning's failure to ensure proper application of suprapubic pressure. (R. p. 204 line 23 to 205 line 8, 207 lines 5-19). The nurse who attempted suprapubic pressure explained she applies suprapubic pressure by pushing down on the bone. Dr. Pliskow stated this is incorrect and harmful. Pushing down on the pubic bone only makes the obstruction worse. (R. p. 185 line 24 to 186 line 8, 207 lines 15-19). Dr. Browning admitted this is not how suprapubic should be performed. (R. p. 515 line 14 to 516 line 5, 520 lines 9-15, 521 lines 3-9).[1] Dr. Pliskow noted the video confirms incorrect application of suprapubic pressure. (R. p. 210 line 25 to 211 line 13, 212 line 11 to 213 line 4, 218 lines 11-13, 220 lines 6-8).

Third, Dr. Browning breached applicable standards by using excessive downward force to instead of one of several safe maneuvers available to resolve shoulder dystocia. (R. p. 208 line 13 to 209 line 6). Using the video, Dr. Pliskow pointed out the four times Dr. Browning pulled down on Julia's head while her body is stuck in the birth canal. (R. p. 217 line 4 to 218 line 16). Dr. Pliskow noted the first pull was not a breach in the standard of care. Dr. Pliskow then explained the subsequent pulls by Dr. Browning were excessive by showing the video and pointing out how much you could see the neck being bent and stretched while Julia's shoulder was stuck behind the mother's pubic bone. (R. p. 218 line 21 to 221 line 12). Based on video evidence, Dr. Pliskow stated the doctor's actions were beyond ordinary negligence. (R. p. 227 line 18 to 228 line 9).

---

[1] Dr. Browning simply shrugged off Misty's incorrect description, claiming she just didn't mean what she said. ("Q: And you saw in her testimony that she pushes down on the pubic bone itself rather than reaching upwards toward where the shoulder is stuck? A: I doubt she meant that. Q. You doubt she meant that? A. Yep." (R. p. 515 lines 20-25).

Dr. Pliskow concluded these breaches were the direct cause of Julia's nerve injury. (R. p. 210 lines 8-16, 223 lines 4-22). In addition to training and experience, Dr. Pliskow relied upon a study which showed that a decade after one hospital implemented a long-term shoulder dystocia management training program, that hospital reduced its number of permanent brachial plexus birth injuries to zero. (R. p. 237 line 8 to 238 line 5). Dr. John A.I. Grossman, one of the world's leading surgeons in brachial plexus nerve surgeries, confirmed the same, noting the injury resulted from force applied across the brachial plexus nerves when the baby is being delivered. (R. p. 117 line 22 to 118 line 6, 127 lines 5-14, 130 line 25 to 131 line 24). Dr. Resnick, who served as chief of pediatric neurology at Miami Children's Hospital, confirmed the same. (R. p. 307 lines 11-20, 308 line 23 to 309 line 6).

In anticipation of Respondents' obstetric emergency defense, Dr. Pliskow offered conclusions regarding "medical stability" and discussed the timing of the risks associated with shoulder dystocia. Julia's delivery took 45 seconds from the time the head delivered to the time of complete delivery. (R. p. 242 line 22 to 243 line 1). The Apgar scores were 9 and 9. (R. p. 243:5). He explained the score relates to the baby's color, breathing, tone, movement, respiratory rate and heart rate. (R. p. 244 line 13 to 245 line 4). The score is taken at 1 and 5 minutes, and a score of 9 and 9 is about as good as you can get. *Id.* The cord blood gases were within the normal limits, indicating the baby was okay. (R. p. 247 lines 10-18). Finally, Dr. Pliskow explained the fetal heart monitoring strips showed that Julia and her mother were medically stable throughout the entire labor and delivery. (R. p. 249 lines 3-15). At no point was the mother or child at any immediate threat of death or serious bodily injury. (R. p. 249 lines 16-18). Dr. Pliskow explained that because the shoulder dystocia lasted only 45 seconds and the heart monitoring strips were good, the mother

and baby were not at risk of any harm, and both mom and baby were medically stable. (R. p. 249 line 25 to 250 line 25). This was confirmed by the Apgar scores and cord blood gases.

Dr. Browning admitted there was plenty of time to do the maneuvers available to safely resolve the shoulder dystocia. (R. p. 526 lines 9-19). He admitted that in the first five to seven minutes of a shoulder dystocia, it is never proper to use excessive traction, and it is certainly inappropriate to do so in the first forty-five seconds. (R. p. 529 lines 12-21). Dr. Browning admitted it was his personal belief that Julia was never in immediate threat of brain damage. (R. p. 530 lines 5-8). He admitted the Apgar scores were good and that they showed Julia delivered before any medical instability. (R. p. 531 lines 1-4). Dr. Browning believed the cord gases showed Julia was doing very well. (R. p. 532 lines 2-7). Dr. Browning admitted the fetal strips did not include any signs he found particularly troubling or that would lead him to believe the baby was in imminent danger. (R. p. 533 lines 10-23). Finally, Dr. Browning conceded that he believed when shoulder dystocia is resolved before two minutes, there's no immediate risk of any serious harm. (R. p. 531 line 22 to 532 line 1).

ARGUMENT

I. THE TRIAL COURT ERRED BY NOT DETERMINING THE OBSTETRIC EMERGENCY AFFIRMATIVE DEFENSE FAILED AS A MATTER OF LAW.

a. Introduction

When defense expert Dr. Ernest was asked whether shoulder dystocia is a medically stable situation, he responded, "Well, it depends on how you define medically stable . . . and I think it's really important." (R. p. 674 lines 8-12). We couldn't agree more. The legislature enacted S.C. Code Ann. § 15-32-230 in 2005. That statute granted physicians immunity from the consequences of their own negligent actions, no matter the severity of harm or obviousness of error, *but only if* strict requirements were met. The physician must prove: (1) the care in question was rendered in

a genuine emergency situation, (2) the patient is not medically stable, and (3) the patient is in immediate threat of either death or serious bodily injury. Each element is distinct and must be proven before the physician is immunized from the consequences of his negligence.

The statute does not give definition to "genuine emergency," "medically stable," or "immediate threat." Additionally, there are questions concerning what evidence is competent to establish these requirements. Must the evidence have been knowable during the time care was rendered or would evidence knowable after the emergency ended be competent to prove the elements? Must the evidence have been actually known by the physician, or would the fact that it could have been known be sufficient? Do the elements relate to the doctor's subjective belief or is the objective determination that the elements existed what matters? Is it sufficient to discuss the medical situation in a general sense or must the defendant establish the elements as they relate specifically to the facts of the case? Is an expert free to define these terms however he wishes? These are the questions this Court must answer to address the issues raised, and the answers will ultimately provide guidance to the bench and bar for future cases involving this statute. Without guidance, an expert is free to define and construe the statute in whatever manner best suits the needs of the party retaining his services.

b. S.C. Code 15-32-230 is a statute in derogation of the common law

At common law, the plaintiff in a medical malpractice lawsuit must:

> (1) Present evidence of the generally recognized practices and procedures which would be exercised by competent practitioners in a defendant doctor's field of medicine under the same or similar circumstances, AND
>
> (2) Present evidence that the defendant doctor departed from the recognized and generally accepted standards, practices and procedures in the manner alleged by the plaintiff.
>
> *Cox v. Lund*, 286 S.C. 410, 414, 334 S.E.2d 116, 118 (1985).

S.C. Code Ann. § 15-32-230 abrogated common law principles of physician liability for ordinary negligence. If this statute applies, then a physician cannot be held liable for ordinary negligence and can only be held liable for gross negligence. "[S]tatutes in derogation of the common law are to be strictly construed." *Grier v. AMISUB of S.C., Inc.*, 397 S.C. 532, 536, 725 S.E.2d 693, 696, (2012) citing *Epstein v. Coastal Timber Co.*, 393 S.C. 276, 285, 711 S.E.2d 912, 917 (2011). Additionally, "Under this rule, a statute restricting the common law will 'not be extended beyond the clear intent of the legislature.'" *Id.* citing *Crosby v. Glasscock Trucking Co.*, 340 S.C. 626, 628, 532 S.E.2d 856, 857 (2000).

Section 15-32-320 is in derogation of the common law. Therefore, it must be strictly construed in a manner that disturbs long-standing common law only to the extent necessary to effectuate the clear intent of the legislature. *See also Velazquez v. Jiminez,* 172 N.J. 240, 257, 798 A.2d 51, 62, (N.J. 2002) (noting courts give "'narrow range' to statutes granting immunity from tort liability because they leave 'unredressed injury and loss resulting from wrongful conduct.'").

c. The defendant has the burden of proving all elements of an affirmative defense

S.C. Code Ann. § 15-32-230 grants immunity to physicians from ordinary negligence if they prove its elements. It is an affirmative defense that must be pleaded or is waived. *Howard v. South Carolina Dep't of Highways*, 343 S.C. 149, 155, 538 S.E.2d 291, 294 (Ct. App. 2000) ("Affirmative defenses are waived if not pled."). In accordance with this requirement, Respondents pled the obstetrical care exception as an affirmative defense.

The mere pleading of an affirmative defense without supporting evidence is insufficient. It is incumbent upon the defense to present evidence supporting each of its elements. South Carolina Courts have noted, "It is well established that a party pleading an affirmative defense has the burden of proving it. *Cole v. S.C. Elec. & Gas, Inc.*, 355 S.C. 183, 195, 584 S.E.2d 405, 412 (Ct. App. 2003), citing *Pike v. South Carolina Dep't of Transp.*, 343 S.C. 224, 540 S.E.2d 87 (2000).

"When a defendant interposes an affirmative defense, he becomes as to that matter the actor in the suit, and the burden of proof rests upon him to establish his affirmative defense by the preponderance of the evidence." *Id.* citing *Lorick & Lowrance, Inc. v. Julius H. Walker & Co.*, 153 S.C. 309, 318, 150 S.E. 789, 792 (1929). Accordingly, a defendant cannot rest upon a factually unfounded, unsupported affirmative defense, nor should the same be presented to the jury for determination. *See Hoffman v. Greenville*, 242 S.C. 34, 40-41, 129 S.E.2d 757, 760-761 (1963) (holding that the trial judge properly refrained from charging an affirmative defense to the jury where there was no proof of such a defense).

S.C. Code Ann. § 15-32-230)[2] subsections (A) and (C) read:

> (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.
>
> (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.

Thus, for a physician to be granted immunity from negligent acts that at common law he would otherwise be responsible for, he must prove *all* the required elements. For a medical malpractice claim arising out of obstetrical care, a defendant physician must prove: (1) the claim arises out of care rendered in a genuine emergency situation, (2) the patient is not medically stable, and (3) the patient is in immediate threat of either death or serious bodily injury.[3] If the physician proves each

[2] Section (B) involves a claim where there is "no previous doctor/patient relationship" between the physician and the patient or the patient did not receive prenatal care. This section is not applicable to the facts of this litigation.

[3] Additionally, the statute explains this limitation on liability only applies to care rendered prior to the patient's discharge from the emergency department or the obstetrical or surgical suite.

requirement, then he is not responsible the harms caused by his negligence unless the plaintiff proves gross negligence.

d. Each element must have meaning distinct from the other elements

The legislature set forth three distinct requirements that the defendant physician must prove if he wishes to be immune from his own acts of negligence. This was deliberate. The statute should be read in a manner which gives every word meaning and every element a purpose. To define or interpret any one element in a manner which makes it identical to one of the others would render that element meaningless. Such could not have been the intent of the legislature.

Therefore, the criteria by which one must determine medical instability must be different from how one determines the presence of a genuine emergency and how one determines if there is an immediate threat of death or serious injury. One element cannot be a mere restatement of the others, as this would render statutory language superfluous and without purpose. *See In re Decker*, 322 S.C. 215, 219, 471 S.E.2d 462, 463, (1995) ("A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplus age, or superfluous . . . ." 82 C.J.S. Statutes § 346.). The statute as written recognizes that while there may be a genuine emergency with an immediate threat of serious harm, the patient may nevertheless be medically stable. If the patient is medically stable, then the physician is not immune from liability for his negligence.

e. Respondents failed to prove that "the patient is not medically stable"

i. All objective evidence shows the patient was medically stable

Appellant concedes this claim arose out of care rendered in a genuine emergency situation and that the patient received care in an obstetrical suite. However, Appellant does not concede and Respondents were required to prove that "the patient is not medically stable." Respondents failed to do so. Therefore, the trial court should have determined Respondents' obstetric emergency

affirmative defense failed as a matter of law. The trial court's decision to send this question to the jury was error which prejudiced the Appellant by requiring her to prove gross negligence.

The statute refers to a singular patient when it states, "*the* patient is not medically stable." In a delivery, the obstetrician has two patients, the mother and the baby. Presumably, the statute refers to the patient alleging harm by medical malpractice. This is the infant Julia in this case. Therefore, Respondents needed to prove that the infant patient "is not medically stable."

The only objective evidence of record clearly establishes Julia was medically stable throughout the labor and delivery. There are three pieces of evidence which show Julia's condition: the fetal monitoring strips, the Apgar scores, and the cord blood gases. No other evidence was discussed as providing any insight into the stability of the patient. Each of these three pieces of evidence clearly shows Julia was in fact medically stable.

First, the fetal heart monitoring strips establish that Julia was medically stable throughout labor and delivery. The strips provide information on the mother's contractions as well as the infant's heart rate, heart rate variability, and response of heart rate to uterine contractions. (R. p. 248 line 17 to 249 line 2). It is like taking the baby's vital signs during the labor and looking at the pulse rate. *Id.* Dr. Pliskow stated the strips in this case showed Julia was medically stable throughout the whole labor and delivery. (R. p. 249:3-11). No expert for the defense ever testified that the strips were poor or that they showed Julia was not medically stable at any time. In fact, Dr. Browning agreed that the strips did not show troubling signs such as reduced variability or late or persistent decelerations. (R. p. 533 lines 10-23). The OBGYN defense expert Dr. Smithson stated, "the fetal heart rate monitor strips showed that the infant tolerated labor very well." (R. p. 614 line 25 to 516 line 2). The OBGYN defense expert Dr. Ernest stated, "Well, the baby's heart rate was stable; so there was a medically stable heart rate." (R. p. 674 lines 14-15). Accordingly,

Appellant's experts, Respondents' experts, and Defendant Dr. Browning himself all agree the strips show the infant was doing well.

The strips provide real-time information that is knowable by the physician throughout labor and delivery. Additional information received from tests after Julia was born confirmed she was medically stable. This included the Apgar scores. The Apgar score relates to the baby's color, breathing, tone, movement, respiratory rate and heart rate. (R. p. 244 line 13 to 245 line 4). In this case, Julia's APGAR scores at 1 and 5 minutes were 9 and 9. (R. p. 243 line 5). This is about as good as one can get. Dr. Browning even admitted the Apgar scores were good and that they "showed the baby was delivered before there was any medical instability." (R. p. 530 line 23 to 531 line 4). Dr. Smithson admitted "Of course, we can say that the baby's Apgars were fine." (R. p. 617 lines 1-4). Therefore, Appellant's experts, Respondents' experts, and the defendant himself all agree the Apgar scores showed Julia was medically stable during the delivery. Similarly, the cord blood gases, which are drawn after birth, showed that the patient was medically stable throughout the delivery. Dr. Pliskow explained the cord blood gases were within the normal limits, indicating the baby was okay. (R. p. 247 lines 10-18). Dr. Browning stated he believed the cord gases also showed the child was doing very well. (R. p. 532 lines 2-7). Dr. Smithson agreed that while the blood gases might have shown some minor abnormalities, "in hindsight we can say that the baby was medically stable." (R. p. 617 lines 3-6). Again, Appellant's experts, Respondents' experts, and the defendant himself all agreed the cord blood gases showed the patient was medically stable.

There is unanimous agreement among plaintiff and defense experts, and the defendant himself that all objective evidence shows the patient was medically stable. The strips, Apgars, and cord blood gases all confirm this. However, Respondents attempt to escape this reality by arguing

the Apgars and cord blood gases are only known "in hindsight." Dr. Browning admitted the evidence showed "the baby was delivered before there was any medical instability." (R. p. 531 lines 1-4). Dr. Browning was asked, "So at no time in those 45 seconds were the patients medically unstable?" to which he responded, "In hindsight, no." (R. p. 531 lines 5-7). Dr. Smithson admitted in "hindsight we know that the baby was medically stable." (R. p. 616 lines 18-25).

Respondents overlook that even if the Apgars and cord blood gases were not known until after delivery, the heart monitoring strips provided information in real-time throughout the delivery. This information was not known "in hindsight," and everyone agreed the strips showed the baby was doing fine. Therefore, it is no defense to argue that the Apgars and cord gases were only known in hindsight because the heart monitoring strips still showed real-time medical stability. The Apgars and cord gases merely confirmed what was already known and shown on the strips. The defense experts never presented any medical evidence known by the doctor during the delivery that showed medical instability. They presented no evidence to contradict the strips. Therefore, the defense experts' cries of "hindsight" ignore the evidence of record known and knowable during the delivery which demonstrates medical stability.

ii. Defense experts picked a definition of "medically stable" that defies ordinary meaning and takes the statute beyond its intent

When asked if shoulder dystocia is a medically stable situation, Dr. Ernest answered, "Well, it depends on how you define medically stable." (R. p. 674 lines 8-12). Dr. Ernest then explained what medical stability meant to him, at least as the term relates to the opinion he was paid to provide to support the defendant physician. Dr. Ernest stated:

> If you talk about a particular part of the baby, is the heart rate stable? Well, the baby's heart rate was stable; so there was a medically stable heart rate. If you talk about the brain, during the 45 seconds of this delivery, the baby's brain was medically stable, but if you look at the big picture, it was a medically unstable condition.
>
> (R. p. 674 lines 13-18).

Per Dr. Ernest, even if the objective medical evidence like heart rate or brain status show a medical stability, the baby still could be medically unstable if you contrive a favorable definition. Dr. Ernest asks us to "look at the big picture," but from what is the big picture comprised if not medical evidence?[4]

Dr. Ernest provides an analogy to show what he considers the scope of medical instability. He gives the scenario where he trips and gets a cut on his forehead that starts to bleed. He can talk, walk, breathe, he has a good heart rate, his heart is fine, his brain is fine, but the cut is bleeding. Dr. Ernest said if someone puts pressure on this cut or if he gets stitches, then he'd be fine. Dr. Ernest concludes, "I might not have even lost enough blood to be transfused, but it is a medically unstable condition . . ." (R. p. 674 line 19 to 675 line 10). Dr. Ernest then relates his scenario to this case, stating, "so I think that's a little bit like what happens with the shoulder dystocia." (R. p. 675 lines 11-14).

Per Dr. Ernest, if you have a cut on your head that needs a stitch, you are medically unstable. You are medically unstable even if the bleeding will stop from minor medical attention such as a stitch or even just pressure. You are unstable even if you have only just begun to bleed and your vitals are completely normal. According to Dr. Earnest, this is all that is necessary.

Dr. Ernest's analogy highlights the absurdity of his position. He has defined medical instability so broadly it is unclear what the statute would not cover. When is a cut that can be stopped from bleeding by a stitch or even just pressure medical instability, even from a layman's perspective? Where does speculation on potential future occurrences and condition changes stop? What if the patient theoretically might have a blood clotting disorder? If left un-sanitized, the cut might get infected. What if the patient has a compromised immune system? Never mind none of this is present. Even if blood loss eventually leads to death, what relevancy does that have to assessing a specific patient's status at

[4] Dr. Ernest's entire discussion of medical instability contradicts his deposition testimony. The deposition transcript reads: Q: No question the Byrd child was medically stable throughout labor, delivery, including the shoulder dystocia resolution time of 45 seconds? A: Because Dr. Browning did a very expeditious and safe delivery, that's exactly right. (R. p. 748 lines 9-18). Only at trial did Dr. Ernest first start describing the potential for instability, in a general sense.

a specific point in time? Is the doctor placing the stitch providing care to an unstable patient simply because bleeding is bad, without regard to the patient's actual medical status? Is the patient medically unstable even though he was cut only a moment ago and is walking, talking, moving, breathing, has a good pulse, and has no signs or symptoms his condition is changing for the worse? Any honest definition of stability requires the answer to be no. Most outside the medical field might not be familiar with shoulder dystocia. However, hopefully Dr. Ernest's claim that shoulder dystocia is like a person with a cut in need of a stitch puts the question of medical stability in its proper perspective.

Additionally, Dr. Ernest's definition of medical instability pays no regard to the actual, current status of the patient. He discusses a person who might, potentially, in the future, lose sufficient blood to become at risk of serious harm, despite there being no discussion of the person presently showing any signs of instability. The statute is very clear. It states the limitation applies if "the patient ***is*** not medically stable." It requires actual medical instability, not the risk of it. If the legislature had intended this, it certainly knew how to draft the statute for this effect. One need only look at the remainder of the same sentence to see how this could have been accomplished. Subsection (C) continues, "and (1) in immediate ***threat*** of death . . . ." The legislature could easily have modified "medically stable," with a word such as "threat" "risk," or "potential." It did not. Therefore, these additional words should not be read into the statute. "In interpreting a statute, words must be given their plain and ordinary meaning without resorting to subtle or forced construction to limit or expand the statute's operation." *Rowe v. Hyatt*, 321 S.C. 366, 369, 468 S.E.2d 649, 650 (1996).

Alluding to the possibility the patient might incur future harm if the situation is not resolved relates only to whether there is an immediate threat of injury. Such a definition renders this element indistinguishable from the third and gives "medical stability" no purpose within the statute. The statute must be interpreted in a manner that gives each word, each element, meaning and not render any language superfluous. As such, Dr. Ernest's definition cannot stand. Because Dr. Earnest contrived a

definition of medical stability far beyond any reasonable understanding of the term and the plain language of the statute, his testimony fails to support the element.

Dr. Smithson attempted the same.[5] In describing shoulder dystocia, Dr. Smithson stated:

> It's no different than somebody who lives through surgery. When they are in surgery, they are not medically stable. When they're on a respirator, they are not medically stable. When they get done with the surgery and they survive, then you can look back and say they're medically table.

(R. p. 617 lines 8-12).

Thus, per Dr. Smithson, the instant any surgical procedure begins on a patient, the patient is medically unstable. Again, this is patently absurd. Defense experts cannot stretch the statute beyond the bounds of its intention to immunize every doctor from negligence committed during surgery. A reasonable definition of the term does not allow it. If this were the case, every patient receiving knee replacements, hip replacement, gall bladder removal, implants, C-sections, and literally any procedure that technically qualifies as surgery would be medically unstable the moment the procedure began. Surgery itself does not render a patient unstable. Legislative intent was not to immunize doctors from negligence under every circumstance for which their services were required. The statute sets forth the requirements for immunity, and these requirements must be understood by their ordinary terms and strictly construed. For this reason, Dr. Smithson's purported definition of medical instability fails to lend any support that Julia was not medically stable during her delivery.

"Stable" has been defined as "not changing or fluctuating." *Merriam-Webster Medical Dictionary*, https://www.merriam-webster.com/dictionary/stable#medicalDictionary, February 2, 2017. Julia's condition did not change. It was not fluctuating. The fetal strips showed Julia was doing well. Had problematic changes appeared on the strips then Julia might not have been medically stable.

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[5] As with Dr. Ernest, Dr. Smithson completely changed his opinion regarding medical stability for trial. The deposition transcript, as read in court, reads: Q: is it your opinion then that this child was medically stable at all times through delivery of the body? A: As best I can tell from the medical record, yes. The baby seemed to be fine. (R. p. 616 lines 5-14). Only at trial did Dr. Smithson first describe his assessment of medical stability as one involving hindsight.

However, this never occurred. The strips showed no change in her condition. The defense experts cited to no evidence showing any change or fluctuation in condition. Therefore, based upon a realistic definition instead of a self-serving one, Julia was medically stable throughout the shoulder dystocia. Any effort to discuss how her condition might have changed if it had lasted longer is irrelevant. The statute by its language does not discuss potential, threat, or risk of instability. It requires actual instability. Based upon a medical dictionary definition of stable, Julia was medically stable throughout the shoulder dystocia. Therefore, it was error not to rule as a matter of law that the obstetric emergency affirmative defense did not apply to the facts of this case, and Appellant was prejudiced as a result.

iii. Respondents never showed the patient in this specific delivery was not medically stable

Finally, Dr. Ernest only discussed in a general sense whether or not delivering a baby when shoulder dystocia is encountered is a medically stable situation. He failed to tie anything about the specifics of this delivery to a determination that this child was not medically stable at any point during this shoulder dystocia. Dr. Ernest cited nothing in the medical record to support his bald conclusion of medical instability. He merely stated, like the person with a cut on his head, it is a medically unstable situation when a delivery is complicated by shoulder dystocia. Drs. Smithson and the defendant also failed to tie general discussion of the condition to the factual presentation of this specific patient.

A claim of general medical instability no better proves actual medical instability than if a plaintiff were to claim that, generally, this type of injury is caused by "X" without stating specifically that "X" caused the injury in the case at hand. Just as discussion of general causation would fail to satisfy the requirement of specific causation, so too does a bald claim that a situation is, generally, medically unstable fail to the satisfy statutory requirement of Section 15-32-230. Respondents were required to tie a finding of medical instability to the specifics of this case. They did not and as such, Respondents failed to prove medical instability.

f. Dr. Browning admitted that he believed the patient was not in immediate threat of death or serious bodily injury

The issue regarding whether the patient in this case was "in immediate threat of death" or serious harm turns on a different issue than previously discussed for medical stability. With respect to this element, the defendant doctor clearly and unequivocally *admitted* there was no immediate risk of serious injury. As such, the defendant doctor's stated subjective belief that he never thought the patient was in immediate risk of serious harm required a finding that the obstetric emergency affirmative defense failed as a matter of law.

Dr. Browning was asked the following:

> Q: This child was never at immediate threat of brain damage in those 45 seconds, was she?
>
> A: No, but you're not – what you're thinking is to resolve this right away in a correct fashion.
>
> Q: No patient as at risk or at immediate threat of death or serious permanent – or serious bodily injury during those 45 seconds; true?
>
> A: Well, at the very start of recognizing the shoulder dystocia, that threat of brain injury, that threat of death is there. You go through your motions. You're not looking at the clock to resolve that problem.
>
> Q: But there's no immediate threat for at least five to seven minutes; true?
>
> A: Well, I would say that when you start getting over two or three minutes, there's increasing risk of problems.
>
> Q: But in the first 45 seconds, there's no immediate threat of any serious harm; true?
>
> A: True.
>
> (R. p. 530 lines 5-22).

No amount of defense expert testimony can un-ring this bell. By Dr. Browning's own admission, he did not believe this child was in immediate threat of serious harm. Julia's delivery took forty-five seconds from the time the head delivered to the time of complete delivery. (R. p. 242 line 22 to 343 line 1). Although Dr. Browning stated that around three minutes he would have concerns, this

delivery finished in forty-five seconds. Dr. Browning admitted there was plenty of time to do additional maneuvers. (R. p. 526 lines 9-19). Dr. Browning continued:

> Q: As long as the shoulder dystocia is resolved within forty-five seconds, you know, as you said before the two minute mark, there's no immediate risk of any serious harm?
>
> A: Right. Generally.
>
> (R. p. 531 line 22 to 532 line 1).

Dr. Browning's admission should have closed the door to his use of the obstetric emergency shield from liability for his own negligence.

The defense experts can try to describe the situation however they wish, but the truth is Dr. Browning, when managing this shoulder dystocia, did not believe the child was at immediate risk of serious harm. Dr. Browning admitted that he would not have believed the child was at immediate risk of serious harm until approximately two to three minutes had passed. In this case, only forty-five seconds had passed. The defendant physician's subjective belief that a situation created an immediate threat (or that the patient was not medically stable) certainly requires competent evidence that objectively establishes the same. Otherwise, the physician could simply claim he believed there was an immediate risk and skirt liability, no matter how preposterous the claim might be. However, a statement by the defendant that he *did not* believe the situation created an immediate risk of harm ends the inquiry.

By analogy, assume there is a claim of self-defense in a criminal trial, but then the defendant takes the stand and testifies she never actually believed she was in danger. Would it matter if several defense experts testified that a reasonable person in the same situation would have believed herself to be at risk of harm? No. The admission ends the inquiry. Not only must a reasonable person have entertained the belief, but the defendant must have believed it herself. If

not, there is no defense. Similarly, for a physician to be immune from negligent acts, the physician must have actually believed the patient was in immediate threat of harm. Otherwise, what would be the rationale for protecting him from negligence? He must have appreciated that the situation involved an immediate threat of harm (or a genuine emergency or that the patient is not medically stable). Because Dr. Browning admitted he did not believe the patient was in immediate threat of harm, he is not protected by the statute. Therefore, the trial court erred by allowing the jury to determine if the statute applied instead of ruling as a matter of law that it did not.

g. Appellant was prejudiced by the trial court's ruling

If the parties agree to anything, it should be that if the trial court's ruling was in error, then Appellant has been prejudiced. Without the obstetric emergency affirmative defense, Respondents would have been responsible for their ordinary negligence. With the defense, Appellant must prove Respondents were grossly negligent. The jury determined the defense applied. Therefore, instead of having to determine whether the physician had exercised reasonable care in the circumstances, the jury had to determine whether the physician failed to exercise even the slightest of care in the circumstances. Moving the evidentiary burden from ordinary negligence to gross negligence clearly prejudiced Appellant. Therefore, the trial court committed reversible error by failing to rule the obstetric emergency affirmative defense had not been established as a matter of law.

CONCLUSION

Until clarity on the obstetric emergency affirmative defense statute is obtained, experts will define its terms however they see fit to serve the needs of their employer. With a few words, Drs. Smithson and Ernest immunized from ordinary negligence all fellow physicians who treat patients in need of surgery, or who need only a stitch. This tortured definition does not reflect the intent of the legislature. All objective medical evidence in this case showed medical stability. Discussing shoulder dystocia generally as medically unstable per one's own contrived definition is

insufficient. Discussing potential or future changes in the patient's condition is insufficient. Moreover, Defendant Browning took this affirmative defense off the table when he conceded one of its elements was not present. No amount of paid expert testimony changes Dr. Browning's concession that he believed the patient was not in immediate threat of harm.

For the foregoing reasons, the trial court erred by not determining the obstetric emergency affirmative defense failed as a matter of law. The jury determined the defense applied, and Appellant was prejudiced as a result. Therefore, Appellant respectfully requests this court reverse the decision of the trial court and grant Appellant's motion for a new trial absolute.

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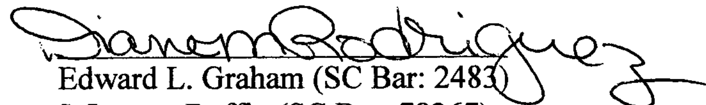

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

William H. Seals, Jr., Circuit Court Judge

Appellate Case No. 2016-001551

Christy Byrd, as Next Friend of Julia B., a minor, ... Appellant,

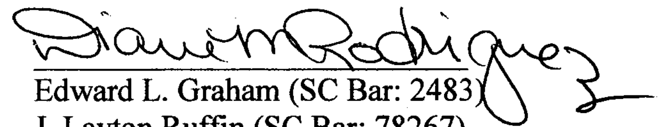
v.

McLeod Physician Associates II and Dr. John B. Browning, ... Respondents.

CERTIFICATE OF COUNSEL

The undersigned counsel for Appellant certifies that this ***Final Brief of Appellant*** complies with Rule 211(b), SCACR.

GRAHAM LAW FIRM, P.A.



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