STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

Appeal from Georgetown County
Court of Common Pleas

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SC Court of Appeals

Larry Hyman, Circuit Court Judge

Case No. 2016-CP-22-00863
Appellate Case No. 2019-001304

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

Appellant,

v.

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

Respondent.

FINAL BRIEF OF RESPONDENT

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STATEMENT OF THE ISSUES ON APPEAL

Respondent would restate the issues on appeal as:

Did the Trial Court properly deny the Plaintiff 's motion for a directed verdict on the limitation of medical malpractice liability provided for in the emergency medical and obstetrical care statute, S.C. Code Ann. § 15-32-230?

I. Does subsection (B) limit the availability of the emergency medical and obstetrical care exception only to those cases where the plaintiff mother was not an established patient of the defendant obstetrician or where the patient had not received prenatal care?

OR, as otherwise stated:

Is the emergency medical and obstetrical care exception provided in subsection (A) potentially available to a defendant obstetrician as a defense in any action brought by an established patient based on allegations of medical malpractice in connection with a genuine emergency during delivery in an obstetrical suite?

II. Did the Trial Court properly submit the emergency medical and obstetrical care exception of § 15-32-230(A) to the jury as an affirmative defense where:

A. There was conflicting evidence as to whether the presentation of shoulder dystocia constituted "a genuine emergency situation."

B There was conflicting evidence as to whether the Mother and/or Infant's condition was "not medically stable."

C. There was conflicting evidence as to whether the Mother and/or Infant was "in immediate threat of death" or "in immediate threat of serious bodily injury."

D. The Plaintiff did not object to the verdict form submitting each of these questions to the jury.

STATEMENT OF THE CASE

This is a medical malpractice action arising out of the labor and delivery of a baby boy, Jahmerican M. (hereinafter referred to as Infant) on April 27, 2013. His mother, Phillippa Smalling (hereinafter referred to as Patient or Mother), brought this action on behalf of her minor child, seeking damages for a permanent brachial plexus nerve injury that the Infant suffered during delivery. She originally filed a summons and complaint on October 12, 2016, alleging that her Obstetrician, Dr. Lisa R. Maselli individually and on behalf of her practice (hereinafter referred to as Dr. Maselli or the Obstetrician) failed to properly manage and resolve a presentation of shoulder dystocia which occurred during the delivery. Thereafter, an amended complaint was filed to correctly identify the physician practice group. [ROA 31; Amended Complaint, filed March 23, 2017.]

Dr. Maselli filed an answer to the amended complaint, by which the Defendant denies the allegations of negligence and assert various defenses, including the limitation on liability found in the emergency medical and obstetrical care exception found in S.C. Code Ann. §15-32-230. [ROA 36; Answer to Amended Complaint, filed April 17, 2017.]

The case came to trial before the Honorable Larry Hyman, and a jury in the Georgetown County Court of Common Pleas on April 3-5, 2019. The Defendant made a motion for a directed verdict on liability at the close of the Plaintiff's case which was denied. [ROA 434-35; Tr. 425-26.] The Trial Court did, however, grant the Defendant's motion for a directed verdict on punitive damages. [ROA 435, 441; Tr. 426, 432.] At the close of the Defendant's case, the Defendant renewed her motion for directed verdict. [ROA 810; Tr. 801.] The Plaintiff also moved for partial directed verdict on the emergency medical and obstetrical care statute on two grounds: (1) the limitation of liability in §15-32-230(A) did not apply because of undisputed evidence that the

plaintiff was an established patient who had received prenatal care, and (2) there was no evidence to meet the required element of medical instability under §15-32-230(C). [ROA 806-07; Tr. 797:21 – 798:7. ROA 809-10; Tr. 800:19 – 801:5.] The Trial Court denied all the motions for directed verdict. [ROA 809-10; Tr. 800:13-14, 801:7-11.]

The Trial Court charged the jury on the emergency medical and obstetrical care exception of §15-32-230(A), [ROA 867-68; Tr. 858:11-859:3], and presented a verdict form to the jury with special interrogatories regarding the elements of subsection (C). [ROA 876; Tr. 867.] The jury returned a verdict for Dr. Maselli, answering the questions as to the emergency medical and obstetrical care exception, as follows:

> 3. Did the Defendants prove by a preponderance of the evidence that the events of Jahmerican's delivery constitutes a genuine medical emergency? YES
>
> 4. Did the Defendants prove by a preponderance of the evidence that Jahmerican was not medically stable at the time of the events in question? YES
>
> 5. Did the Defendants prove by a preponderance of the evidence that there was an immediate threat of death or serious bodily injury to Jahmerican at the time of the events in question? YES
>
> 6. Did the Plaintiff prove by a preponderance of the evidence that the Defendants were grossly negligent? NO

[ROA 4; Verdict. See also ROA 891; Tr. 882:8-23.] The jury did not reach the issue of whether Dr. Maselli deviated from the standard of care or whether any such deviation was a proximate cause of the Infant's injuries.

After the jury rendered its verdict, the Plaintiff renewed her motion for a directed verdict and moved for a new trial absolute without stating any grounds or requesting any time to submit written motions. [ROA 895; Tr. 886:17-18.] The Trial Court denied the Plaintiff's motions from the bench. [ROA 895; Tr. 886:19-24.] The Plaintiff filed a Rule 59(e) motion for a new trial on April 15, 2019, and also filed an amended Rule 59(e) motion on April 16, 2019. [ROA 952, 959;

Motion, Amended motion.] The Trial Court issued its order on June 27, 2019, denying both posttrial motions. [ROA 1; Order.] The Plaintiff filed a Notice of Appeal in the Circuit Court on July 1, 2019. [ROA 961; NOA.] The Plaintiff also filed a second Notice of Appeal in the Circuit Court on August 5, 2019. [ROA 958; NOA.]

STATEMENT OF THE FACTS

Medical Evidence of the Shoulder Dystocia Emergency during Labor and Delivery

Phillippa Smalling first became a patient of Dr. Maselli's Group in 2012, when she was diagnosed with her fourth pregnancy. [ROA 473-74; Tr. 464-65.] Her prenatal care proceeded without problems[1] and she was admitted to Georgetown Memorial Hospital for labor and delivery on Saturday, April 27, 2013, at 2:00 am. [ROA 480; Tr. 471.] Dr. Maselli was contacted, as the OB on call for her Group that night, and she arrived at the hospital at 2:41 am. [ROA 469, 482; Tr. 460, 473.] Dr. Maselli remained at the hospital, periodically checking on her Patient's progress through stage one of labor during the early morning hours. [ROA 489; Tr. 480.] At points in time, the Patient received an epidural and Pitocin[2] was administered when the contractions slowed. By 7:59 am, when the Patient had reached 10 centimeters dilation and zero station, she was ready for delivery and she began pushing. [ROA 487, 492; Tr. 478, 483.] At 8:14 am, the Infant's head delivered and the nuchal cord was wrapped around it, but Dr. Maselli was able to reduce it within seconds without any trouble. [ROA 488, 500; Tr. 479, 491.] However, Dr. Maselli then recognized that they were facing a shoulder dystocia emergency. [ROA 493-94; Tr. 484:25-485:1.] As described by the Plaintiff's obstetrical expert "with a shoulder dystocia, the head comes

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[1] Plaintiff's obstetrical expert testified that the prenatal care was "fine." [ROA 237; Tr. 228:20-22.]

[2] Plaintiff's obstetrical expert also testified that no deviation from the standard of care in administering the Pitocin. [ROA 237-38; Tr. 228:23 – 229:1.]

out and the baby gets stuck. The shoulders, which is the next part to come out after the head, doesn't come out; it's stuck by the boney structures of the pelvis." [ROA 171-72; Tr. 162:25 – 163:3.]

At the time they entered stage two for delivery of the Infant, Dr. Maselli was being assisted by one obstetrical nurse.[3] Upon realizing that the shoulder was stuck, Dr. Maselli immediately called for help from an additional nurse and they took the appropriate measures to address this medical emergency and delivered the Infant within one minute. [ROA 494-95; Tr.485-86.] First, the nurses performed a McRoberts maneuver by hyperflexing the Patient's thighs. [ROA 494; Tr. 485.] When the next push did not resolve the emergency, Dr. Maselli performed an episiotomy. [ROA 494; Tr. 485.] When the next push still did not produce any movement, Dr. Maselli instructed the nurses to apply suprapubic pressure which successfully released the impacted shoulder, and with the next push, the baby was delivered at 8:15 am. [ROA 495, 499; Tr. 486, 490.]

There was only 60 seconds from the delivery of the head to the delivery of the body. Postdelivery testing (APGAR scores and cord blood gases) showed that, with the relatively quick delivery, the Infant did not suffer any hypoxic injury from oxygen deprivation. [ROA 199, 898-99, 902; Tr. 190, Def. Ex. 5, 8.] However, the Infant did have decreased movement of the right arm from a brachial plexus injury. [ROA 190, 899, 902; Tr. 181, Def. Ex. 5, 8.]

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[3] There also was a pediatrician in the room to provide deep suction once the baby delivered because they had assessed that meconium was present in the amniotic fluid when the Patient's water broke. [ROA 487-88; Tr. 478-79.] That situation was unrelated to the shoulder dystocia emergency.

Expert Opinion Evidence of the Medical Instability and the Immediate Threat to the Infant during a Genuine Emergency

The application of the emergency medical and obstetric care statute, §15-32-230(A) & (C), involves the elements of whether the patients (Mother and/or Infant) were not medically stable and in immediate threat of death or serious injury during a genuine emergency situation. All the obstetrical experts who testified at trial agree that shoulder dystocia is an unpredictable and unpreventable risk to any pregnancy. However, there are divergent opinions between the Plaintiff's and Defense experts as to each element.

The Defense obstetrical experts testified that in the overwhelming majority of cases, shoulder dystocia cannot be predicted or prevented, and they also testified more specifically that this Patient's prenatal care was normal, and there was nothing in her chart to suggest that her shoulder dystocia would have been predictable or preventable. [ROA 637, 732; Tr. 628:11-18 (Dr. Robinson), Tr. 723:7-16 (Dr. Chauhan.] They opined that Dr. Maselli was facing a genuine emergency when the shoulder dystocia occurred during this Patient's delivery. [ROA 638, 645, 752, 759; Tr. 629, 636, 743, 750.] The Plaintiff's obstetrical expert testified that in a general sense, shoulder dystocia is an unpredictable, acute, life threatening emergency, and that there were no red flags to predict or prevent shoulder dystocia in this case. [ROA 248, 240-41; Tr. 239:3-4, Tr. 231-32 (Dr. Pliskow).] However, Plaintiff's expert refused to admit that this case presented a genuine emergency. [ROA 246-48; Tr. 237-39.] Additional detail about these opinions will be discussed below regarding the disputed evidence that justified denying the Plaintiff's directed verdict motion.

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 minutes before the Infant would have suffered brain damage or death. However, the Plaintiff's experts insisted that the Infant and Mother were

medically stable and there was no risk of injury during the 60 seconds that it took Dr. Maselli to resolve the emergency and deliver the Infant. [ROA 124, 189-91; Tr. 115, 180-82.] In contrast, Defense experts opined that the Infant was not medically stable and that the risk was real and immediate even during those first 60 seconds because it was unknown whether the shoulder dystocia could be resolved and how long it would take. [ROA 640-42, 753, 757; Tr. 631-33; Tr. 744, 748.] The details of their opinions on the Infant's unstable condition and the threats to Mother and Infant will be discussed below.

Expert Opinions on the Standard of Care for Resolving a Shoulder Dystocia Emergency

The Plaintiff's and Defense obstetrical experts agreed that utilizing external maneuvers – McRoberts and suprapubic pressure -- are within the standard of care as initial options for resolving a shoulder dystocia emergency. The Plaintiff's accusations of negligence implicated Dr. Maselli's use of traction during that final minute of delivery while she was managing her Patient's shoulder dystocia.

As explained by the experts, "traction" does not mean pulling the infant out – it is the process of guiding the infant through the birth canal while the mother is pushing. [ROA 173, 623, 733; Tr. 164, 614, 724.] One of the Defense obstetrical experts, Dr. Robinson, testified that it is necessary for an obstetrician to apply that some force of traction to deliver a baby: "[T]raction has to be applied for a delivery to actually take place." [ROA 623, 647; Tr. 614, 638:22-23.] Dr. Robinson further testified that: "The amount of traction used is not the same for each delivery." [ROA 650; Tr. 641:8-9.] Another Defense obstetrical expert, Dr. Chauhan, likewise testified that some degree of traction generally is necessary in any delivery. [ROA 734, Tr. 725.]

Dr. Maselli testified that she used moderate, axial traction.[4] [ROA 498, 495; Tr. 489:7, 485.] While Plaintiff's obstetrical expert admitted that there is no way to empirically measure the degree of traction, he opined that Dr. Maselli violated the standard of care in using excessive traction during the delivery because, in his personal view, anything more than gentle traction was excessive. [ROA 207, 253; Tr. 198, 244] In contrast, Dr. Chauhan testified that: "There's absolutely no evidence that excessive traction was used during this delivery." [ROA 731; Tr. 722:13-14.] Dr. Robinson opined that Dr. Maselli was within the standard of care in using moderate controlled axial traction to deliver the baby. [ROA 633; Tr. 624:2-13.] Dr. Chauhan likewise opined that Dr. Maselli's use of moderate controlled traction was appropriate and within the standard of care. [ROA 737, 762; Tr. 728, 753.]

ARGUMENT

THE TRIAL COURT PROPERLY DENIED THE PLAINTIFF'S MOTION FOR A DIRECTED VERDICT ON THE LIMITATION OF PHYSICIAN LIABILITY PROVIDED FOR IN THE EMERGENCY MEDICAL AND OBSTETRICAL CARE STATUTE, S.C. CODE ANN. § 15-32-230(A), WHERE THE EVIDENCE CREATED A JURY QUESTION ON EACH OF THE ELEMENTS.

Standard of Review

> 'In an action at law, on appeal of a case tried by a jury, the jurisdiction of the appellate court extends merely to the correction of errors of law, and a factual finding by the jury will not be disturbed unless a review of the record discloses there is no evidence which reasonably supports the jury's findings.' *Wright v. Craft*, 372 S.C. 1, 18, 640 S.E.2d 486, 495 (Ct. App. 2006).
>
> 'When reviewing a motion for directed verdict or JNOV, an appellate court must employ the same standard as the trial court.' *Id.* 'Motions for directed verdict or JNOV should be denied if the evidence yields more than one reasonable inference or its inference is in doubt.' *Allegro, Inc. v. Scully*, 418 S.C. 24, 32, 791 S.E.2d 140, 144 (2016) (citations omitted). 'An appellate court will reverse the trial court's ruling only if no evidence supports the ruling below.' *Id.*

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[4] Of note, the pediatrician present at the time of delivery testified that Dr. Maselli was not pulling or twisting the baby during the maneuvers. [ROA 603; Tr. 594:21-24.]

Byrd v. McLeod Physician Associates II, 427 S.C. 407, 831 S.E.2d 152, 154 (Ct. App. 2019).

I. The limitation on physician liability for emergency medical and obstetrical care provided in subsection (A) is potentially available to an obstetrician as a defense in any action brought by an established patient based on allegations of medical malpractice in connection with a genuine emergency during a delivery in an obstetrical suite.

The statute in question, S.C. Code § 15-32-230, was enacted as part of the South Carolina Noneconomic Damage Awards Act of 2005. Section § 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.

As will be discussed in detail below, the evidence contains conflicting expert opinions as to whether the shoulder dystocia presented a genuine emergency situation involving an immediate threat of death or serious bodily injury and whether the patient was not medically stable. However, the evidence is undisputed that the Patient Mother was an established patient of Dr. Maselli's

Group who received prenatal care through the clinic, and that the Patient Mother was receiving care in an obstetrical suite at the time of her labor and delivery.

The Plaintiff argues that Dr. Maselli is not entitled to assert the obstetrical emergency defense under subsection (A), as a matter of law, based on that undisputed fact that the Mother was an established patient of Dr. Maselli's Group where she received prenatal care. Her argument -- which she refers to as a "technical legal argument"[5] – appears to be grounded on her theory that subsection (B) controls liability of an obstetrician accused of obstetrical malpractice and only provides limited liability where there was no previous doctor/patient relationship with the physician or her practice group or if the patient had not received prenatal care.

By some illogical reasoning, the Plaintiff contends that §15-32-230 has created two classes of obstetrical patients: (1) established patients which she refers to as "favored patients," and (2) "unfavored patients" such as new patients or those without prenatal care who are treated on an emergency basis. Plaintiff contends that the General Assembly intended to preserve the full common law right of the "favored patients," such as herself, to receive compensation for obstetrical negligence during an emergency without having to prove gross negligence. [Appellant's Brief, p. 13.] However, her argument of statutory interpretation is not supported by the law. There is no foundation in our state law for this "favored" and "unfavored" dichotomy espoused by the Plaintiff. Nor is there any basis for the Plaintiff's speculation of legislative intent to deprive obstetricians of the limitation of liability based on the fact that a claim is made by an established patient.

A countless number of Appellate Court opinions provide a varied assortment of rules for the court to consider when it is called upon to interpret a statute. However, as repeatedly and consistently stated in Court opinions, these corollary rules are to be applied as aids for the court in

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[5] [ROA 712; Tr. 703:7.]

its primary function which is to ascertain and effectuate the legislative intent. "Our primary function in interpreting a statute is to ascertain and give effect to the intention of the Legislature." *Williams v. Quest Diagnostics, Inc.*, 423 S.C. 547, 816 S.E.2d 564, 565 (2018) (citations omitted). "The elementary and cardinal rule of statutory construction is that the court ascertain the intent of the legislature." *Whiteside v. Cherokee Cty. Sch. Dist. No. One*, 311 S.C. 335, 428 S.E.2d 886, 888 (1993). "These rules are not the masters of the courts but merely their servants to aid in ascertaining the legislative intent." *State v. Pilot Life Ins. Co.*, 257 S.C. 383, 397, 186 S.E.2d 262, 270 (1972) (citation omitted). "All rules of statutory construction are subservient to the one that the legislative intent must prevail if it can be reasonably discovered in the language used, and that language must be construed in the light of the intended purpose of the statute." *Singletary v. S.C. Dep't of Educ.*, 316 S.C. 153, 447 S.E.2d 231, 235 (Ct. App. 1994).

Plaintiff focuses on the rule that statutes in derogation of the common law limiting a claimant's right to bring suit are to be strictly construed. While this rule does apply to §15-32-230, *Byrd v. McLeod,* 831 S.E.2d at 155[6], the strict construction rule does not support the Plaintiff's argument that the limitation of liability provided in subsection (B) deprives Dr. Maselli of the limitation of liability provided in subsection (A). The rule of strict construction does not override the preeminent rule that "statutes, as a whole, must receive practical, reasonable and fair interpretation consonant with the purpose, design and policy of lawmakers." *Whiteside v. Cherokee Cty. Sch. Dist. No. One*, 311 S.C. 335, 340, 428 S.E.2d 886, 888 (1993) (citing *Browning v. Hartvigsen*, 307 S.C. 122, 414 S.E.2d 115 (1992)).

The Plaintiff cites to *Whiteside v. Cherokee County Schools* for the proposition that a

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[6] In *Byrd,* §15-32-230(A) was applied in a claim involving a shoulder dystocia emergency with an established OB patient.

specific statute acts as a qualifier to a general statute on the same issue, but it has long been held that the specific over general rule does not apply, "except where there is a repugnance or incompatibility between the specific and general expressions." *State v. Williams,* 33 S.C.L. 474, 477 (S.C. App. L. 1848). "[T]his rule does not apply except in those cases where there is some repugnance or incompatibility between the specific and general expressions." *State v. Holman*, 14 S.C.L. 306, 307 (S.C. App. L. & Eq. 1825).

> Where there is one statute dealing with a subject in general and comprehensive terms and another dealing with a part of the same subject in a more minute and definite way, the two should be read together and harmonized, if possible, with a view to giving effect to a consistent legislative policy; but to the extent of any necessary repugnancy between them, the special will prevail over the general statute.

Smith v. S.C. State Highway Comm'n, 138 S.C. 374, 136 S.E. 487, 488 (1927).

Plaintiff also relies on the 'last legislative expression' rule and argues that somehow (B) trumps (A) because it comes last. However, that rule is one of last resort only to be applied when there is clearly an irreconcilable conflict and other rules of interpretation fail to resolve the conflict. *Eagle Container Co., LLC v. County of Newberry,* 379 S.C. 564, 666 S.E.2d 892, 896 (2008) (citing *Feldman v. S.C. Tax Comm'n,* 203 S.C. 49, 54, 26 S.E.2d 22, 24 (1943)).

Here, there is no repugnancy or irreconcilable conflict between (A) and (B), because each subsection applies to different situations with different elements.

The limitation of liability in (A) applies under a specified set of circumstances:

- to any type of medical care
- rendered in a genuine emergency situation
- to any patient facing an immediate threat of death or serious bodily injury
- in one of three specific venues - an emergency room OR an obstetrical suite OR a surgical suite.

The same gross negligence limitation of liability is made applicable in (B) to a different set of circumstances:

- to obstetrical care
- rendered by a physician on an emergency basis
- to a "new patient" or a patient that has not received prenatal care.

The limitation of liability under both (A) and (B) is only available upon proof of the elements set forth in (C), namely

- the patient is not medically stable;
- the patient is in immediate threat of death or serious bodily injury; and
- the care was rendered prior to the patient's discharge from one of the three specific venues.[7]

It is conceivable that there could be an overlap where a physician would be entitled to limited liability under the provisions of both (A) and (B), but the provisions of (A) and (B) are not coterminous. For example, Section (B) operates where obstetrical care is provided on an emergency basis outside of the Emergency Room, OB suite, or Surgical suite, but where the care for that patient is eventually transitioned to one of those three settings. Once the patient is inside the Emergency Room, OB suite, or Surgical Suite, then Section (A) becomes the operative provision. Finally, under Section (C), in no circumstance will the limitation of liability apply to care provided once the patient is actually discharged from the Emergency Room, OB suite, or Surgical Suite. Thus, Section (A) and (B) reflect the reality that emergencies arise in settings

[7] The additional required elements of medical instability and immediate threats set forth in subsection (C) are discussed below as they were submitted to the jury under the applicable provision of subsection (A).

outside of an Emergency room, OB suite, or Surgical suite. In those settings, Section (B) would apply to the extent its other provisions are met.

The "specific-trumps-the general" and the "last in time" rules are not absolute, controlling rules, but simply two of the many rules that are supposed to guide the court in determining legislative intent and the proposition may be overcome by indications that reconcile the provisions harmoniously such that the specific provision embraced within a general one is not superfluous, but creates a discrete provision that is not mutually exclusive or preemptive. *See Insight Sys. Corp. v. United States*, 110 Fed. Cl. 564, 579 (2013) (citing *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012) ("One can conceive of a statutory scheme in which the specific provision embraced within a general one is not superfluous, because it creates a so-called safe harbor.")). "Redundancies across statutes are not unusual events in drafting, and so long as there is no 'positive repugnancy' between two laws, a court must give effect to both." *Connecticut. Nat'l Bank v. Germain*, 503 U.S. 249, 253 (1992) (citation omitted); *see also Adirondack Med. Ctr. v. Sebelius*, 891 F. Supp. 2d 36, 47 (D.D.C. 2012), aff'd, 740 F.3d 692 (D.C. Cir. 2014)). While there is some overlap/redundancy between (A) and (B), there is no conflict amounting to a repugnancy and applying (A) does not make (B) wholly superfluous.

Plaintiff's argument disregards the rule that statutes are supposed to be construed to give effect to every clause and every part of the statute to produce a consistent and harmonious whole. *Kitchen v. Southern Ry.*, 68 S.C. 554, 48 S.E. 4, 8 (1904); *CFRE, LLC v. Greenville Cty. Assessor*, 395 S.C. 67, 716 S.E.2d 877, 881 (2011). "A construction which would leave without effect any part of the language used should be rejected, if an interpretation can be found which will give it effect." *Kitchen, id.* (citation omitted). "A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous...." *Matter of Decker*, 322

S.C. 215, 471 S.E.2d 462, 463 (1995) (quoting 82 C.J.S. *Statutes* § 346); *Citizens for Quality Rural Living, Inc. v. Greenville County Planning Commission*, 426 S.C. 97, 825 S.E.2d 721, 726 (Ct. App. 2019). The Court "should seek a construction that gives effect to every word of a statute rather than adopting an interpretation that renders a portion meaningless." *Hinton v. South Carolina Dept. of Probation, Parole and Pardon Services*, 357 S.C. 327, 592 S.E.2d 335, 343 (Ct. App. 2004). Plaintiff's interpretation of § 15-32-230(B) would render a portion of subsection (A) meaningless and nullify a limitation of liability given in (A). However, when the two subsections of §15-32-230 are carefully read with proper consideration of these rules of construction, it is clear that the two subsections provide a limitation of liability to physicians in different situations, and the Trial Court correctly charged the jury on the limitation of liability provided in subsection (A) based on the evidence of record in this case.

The words of the Court found in *State v. Pilot Life* are particularly fitting here: "When and where appropriate, the court uses the assorted rules of interpretation to resolve ambiguities, not for the purpose of creating them." 186 S.E.2d at 269. Nor should those rules be used to defeat the obvious purpose of legislation. *See Gooch v. United States*, 297 U.S. 124, 128 (1936). The Plaintiff attempts to create ambiguities in Subsection (B) to avoid the limitation of liability in (A), but (B) is not inconsistent with or repugnant to (A) to the extent that it extends the limitation of liability to encompass a more specific scenario in obstetrical care cases and with an added focus on the relationship between the patient and physician. Subsection (B) applies to a claim arising out of obstetrical care rendered on an emergency basis to a "new" patient that the physician had never treated or to a patient who had never received prenatal care, but this limitation of liability is broader than (A) in that it also applies to obstetrical care provided outside of an Emergency room, OB suite, or Surgical suite. However, nothing in subsection (B) can be rationally construed to

negate the provision of subsection (A) and deprive limited liability to a physician providing obstetrical care to ***an established patient*** in an obstetrical suite when the patient is facing a genuine emergency. Subsection (B) clearly did not apply to the claims made against Dr. Maselli, as a matter of law, given the undisputed fact that the Patient Mother was an established patient of her Group where she received prenatal care, and given the fact that the care was provided inside of an OB suite. Accordingly, the Trial Court properly denied the Plaintiff's motion for directed verdict and the judgment on the jury verdict should be affirmed.

II. The Trial Court properly submitted the emergency medical and obstetrical care exception in subsection (A) to the jury.

The limitation on liability provided in §15-32-230(A) is an affirmative defense and, as such, the defendant physician has the burden of proving all three required elements: "(1) the claim arises out of a genuine emergency situation, (2) the patient is not medically stable, and (3) the patient was under an immediate threat of death or serious bodily injury." *See Byrd*, 831 S.E.2d at 155. Respondent maintains that the Plaintiff did not adequately preserve any issue for appeal regarding the sufficiency of evidence on any of these elements presented to the jury and found in Dr. Maselli's favor. Respondent further maintains that the evidence created questions of fact on each of the elements for the jury to determine.

A. The Plaintiff failed to preserve these issues for appellate review.

The Plaintiff moved for a directed verdict only as to one of these elements – medical instability. [ROA 807; Tr. 798:4-8.] Thus, no issue is preserved for appellate review of the sufficiency of the evidence on the elements of genuine emergency or immediate threats. *Holly Woods Ass'n of Residence Owners v. Hiller*, 392 S.C. 172, 708 S.E.2d 787, 796 (Ct. App. 2011) (motion for directed verdict must present specific basis same as raised in appeal); *Creech v. S.C. Wildlife & Marine Res. Dep't*, 328 S.C. 24, 34, 491 S.E.2d 571, 576 (1997) (holding the appellant's

failure to raise a particular issue in its directed verdict motion precludes appellate review of that issue); *see also* Rule 50(a), SCRCP ("A motion for a directed verdict shall state the specific grounds therefor.").

The Trial Court charged the jury on the §15-32-230(A) exception as follows:

> In an action involving a medical malpractice claim arising out of care rendered in a genuine emergency situation involving an immediate threat or 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. This limitation on physical liability -- physician liability, shall only apply if the patient is not medically stable and immediate threat or death or an immediate threat of serious bodily injury. The defendant has the burden of proving the existence of a genuine emergency situation, the medical instability of the patient, and the immediate threat of a death or serious bodily injury from the higher proof of gross negligence -- for the higher proof of gross negligence to apply. The defendant must make this proof by a preponderance or greater weight of the evidence.

[ROA 867-68; Tr. 858:11 – 859:3.] Consistent with the jury charge, the Trial Court presented the jury with a verdict form containing special interrogatories to address the elements of the emergency obstetrical care exception:

> 3. Did the Defendants prove by a preponderance of the evidence that the events of Jahmerican's delivery constitutes a genuine medical emergency?
>
> 4. Did the Defendants prove by a preponderance of the evidence that Jahmerican was not medically stable at the time of the events in question?
>
> 5. Did the Defendants prove by a preponderance of the evidence that there was an immediate threat of death or serious bodily injury to Jahmerican at the time of the events in question?
>
> 6. Did the Plaintiff prove by a preponderance of the evidence that the Defendants were grossly negligent?

[ROA 4; Verdict.]

The Plaintiff did not object to this instruction on the limitation of liability under subsection A. Rather, the Plaintiff only objected "to the decision not to charge section B of the medical

emergency statute" which corresponded to her "technical legal argument" as discussed above. [ROA 711; Tr. 702:8-9. ROA 712; Tr. 703:1-7.] The Plaintiff did not make any objection to the verdict form. [ROA 713; Tr. 704:18.] By failing to make any objection to the special verdict form that asked the jury to consider all these elements, the Plaintiff waived any argument that she was entitled to directed verdict on the obstetrical emergency exception. *Stephens v. CSX Transp., Inc.*, 415 S.C. 182, 781 S.E.2d 534, 541 (2015); *Byrd v. McLeod*, 831 S.E.2d at 157.

On appeal, the Plaintiff complains that the statute does not define "genuine emergency," "the patient is not medically stable" or "in immediate threat," and proffers definitions of these terms from various online dictionaries.[8] [Appellant's brief, p. 16-18.] However, the Plaintiff did not raise any issue as to the lack of statutory definitions in her directed verdict motion, and she never asked the Trial Court to define those terms in the jury charge. Thus, she failed to preserve such definition issues for appeal. *Byrd v. McLeod*, 831 S.E.2d at 157 (argument not preserved for review where plaintiff did not request any charge to provide a definition of "medical stability" and she did not make any argument related to such definition in her JNOV motion).

[8] Absence of statutory definitions would not render the statute void or unenforceable. See *Briggs v. Greenville County,* 137 S.C. 288, 135 S.E. 153, 155 (1926). As the Trial Court noted, undefined terms are to be taken and understood in their plain and ordinary meaning. [ROA 438; Tr. 429:7-10.] *See Media General Communications, Inc. v. South Carolina Dept. of Revenue*, 388 S.C. 138, 694 S.E.2d 525, 530 (2010) (undefined terms are to be taken and understood in their plain and ordinary sense, "unless it fairly appears from the context that the Legislature intended to use such terms in a technical or peculiar sense.").

B. The evidence created a question of fact for the jury as to whether the presentation of shoulder dystocia constituted "a genuine emergency situation."

The Defendant and her OB experts all testified that the shoulder dystocia was a genuine emergency. Dr. Robinson testified that the crux of a shoulder dystocia emergency is that the baby cannot breathe while only the head has delivered and there is no way for the obstetrician to know how long it will take to resolve the situation and deliver that baby:

> So, anytime that you have an individual that cannot breathe on its own and cannot establish itself outside to be able to continue to thrive and do well, that person is experiencing a genuine emergency, because they have no control over that process of when they're going to come out and none of us knows the minute, second or hour that that is going to take place or that person is going to be able to transition to that. In other words, no one has a crystal ball to tell them what the future is like. We like to focus sometimes on the retrospectrogram, which is to look backwards and say well, this is what happened. None of us have that capability. That's the reason this is an emergency and has to be treated as such, as an emergency.

[ROA 638; Tr. 629:3-15. See also Dr. Maselli – ROA 538; 529:18-20. Dr. Chauhan – ROA 759; Tr. 750:11-17.] In addition, the Pediatrician present at the delivery testified that it was an emergency. [ROA 603; Tr. 594:9-15.] However, the Plaintiff's OB expert refused to admit that shoulder dystocia was a "genuine emergency."

While Plaintiff's obstetrical expert agreed, on cross examination, with recognized, reliable medical literature, that "shoulder dystocia is an unpredictable, acute, life threatening emergency," he refused to admit that this case of shoulder dystocia was a "genuine emergency" and insisted on quibbling about the gravity of the emergency with semantics. [ROA 248; Tr. 239:3-4.] Plaintiff's expert described shoulder dystocia as just an "emergent condition" when it first presents and maintained that it does not spiral into a genuine emergency if resolved quickly. [ROA 246-47; Tr. 237:24–238:6, 239:23.] He did agree, however, "the condition itself can be considered an emergency because at some point, in that condition, life and limb can be at risk." [ROA 249; Tr.

240:4-6.] He also admitted that the obstetrician does not know at what point the condition will become "genuine". [ROA 249; Tr. 240:7-12.] Respondent maintains that the Plaintiff's expert opinion on the "emergent" condition could not negate the Defendant's expert opinion, and merely created a question of fact for the jury as to whether the presentation of shoulder dystocia constituted "a genuine emergency situation." Accordingly, the Trial Court properly denied the Plaintiff's motion for a directed verdict.

On appeal, the Plaintiff argues that shoulder dystocia is not a genuine emergency, as a matter of law, because obstetricians are trained to deal with this obstetrical emergency, citing to *Amodeo v Cumella*, 838 N.Y.S.2d 152, 41 A.D.3d 396 (N.Y.A.D. 2 Dept. 2007). As discussed above, this argument was not raised to the Trial Court and is not preserved for appeal. *See generally Elam v. South Carolina Dept. of Transp.*, 361 S.C 9, 602 S.E.2d 772, 779–80 (2004) ("Issues and arguments are preserved for appellate review only when they are raised to and ruled on by the lower court."). In a medical malpractice case involving shoulder dystocia, the New York trial court had charged the jury on its state common law emergency doctrine regarding a sudden and unforeseeable occurrence not of his or her own making; however, the appellate court held that the charge was reversible error because the physician was trained and prepared for the occurrence of a shoulder dystocia, which is not considered an unforeseen occurrence within the field of obstetrics. The holding is inapposite because this is not the law in South Carolina -- §15-32-230 provides the law for obstetrical emergencies.

C. The evidence created a question of fact for the jury as to whether the Infant and Mother were "not medically stable."

As noted above, the Plaintiff did raise the issue of medical stability in her directed verdict motion: "[T]he only evidence they've put in about medical stability relates to a theory that each and every emergency including shoulder dystocia, involves instability and the instability

represents uncertainty." [ROA 807; Tr. 798:4-8.] Respondent maintains that the Plaintiff waived this issue by failing to object to the verdict form. In any event, however, the expert testimony created a jury question on this element.

Plaintiff's obstetrical expert, Dr. Pliskow, testified that the Infant was medically stable based on the fetal monitoring strips prior to the onset of the shoulder dystocia and the post-delivery APGAR scores and blood gas studies. [ROA 189-90; Tr. 180:22-181:9.] He reasoned that the baby must have been stable during the 60 seconds that the head was stuck since it was stable before and after: "[T]he baby was stable coming in and stable coming out, would have been stable for at that one minute period of time from a oxygen, acid based standpoint." [ROA 191; Tr. 182:12-14.]

Defense obstetrical expert, Dr. Robinson testified that the Infant was medically unstable at the time of the shoulder dystocia because it could not breathe with the head stuck. [ROA 645; Tr. 636:19-22.] He testified that the cord becomes compressed, oxygen flow is cutoff, "times ticking", and every second counts. [ROA 635, 639, 702; Tr. 626, 630, 693:7.] As he stated very simply: "You cannot be stable and not be able to breathe." [ROA 703; Tr. 694:1-2.]

Dr. Robinson explained that the fact that fetal monitoring strips showed the Infant had a good heartrate going into the shoulder dystocia is not a marker of whether he was stable from an oxygen point when the head became stuck. [ROA 643; Tr. 634.] He further explained that the positive postdelivery scores/tests show that Dr. Maselli did a good job in managing the delivery to prevent any hypoxic adverse outcome, but those tests do not have any bearing on whether the Infant was stable during that critical of time while the head was stuck. [ROA 642-43; Tr. 633-34.]

Dr. Chauhan also opined that a baby trapped in shoulder dystocia is in an unstable condition: "It is very unstable because we don't know what will happen within the next 45 seconds or a minute or the next minute." [ROA 757; Tr. 748:18-20.] His opinion further concurred with

the view that the shoulder dystocia presented an unstable condition irrespective of the strong fetal heartbeat, and that the good postdelivery scores/tests were, in fact, "a testament of their excellent clinical work in managing obstetrics." [ROA 758-59; Tr. 749-50:8-9.]

Defendant also presented expert testimony from Dr. Duchowny, a pediatric neurologist, regarding the medical stability of the infant. He opined that when the baby is hung up in the birth canal with a shoulder dystocia it is a medically unstable time. [ROA 914; Def. Ex. 31 - Duchowny Dep. 39:20-23.]

In Plaintiff's opening statement, her counsel stated that it was the jury's "job to think about and determine about whether that baby was stable during that one minute." [ROA 68; Tr. 59:10-11.] The Trial Court properly denied the Plaintiff's motion for a directed verdict and allowed the jury to make that determination on based on the opposing expert opinions they heard.

D. The evidence created a question of fact for the jury as to whether the Infant and Mother were "in immediate threat of death" or "in immediate threat of serious bodily injury."

The Plaintiff's obstetrical expert testified that the risks for the baby associated with shoulder dystocia range from a fractured clavicle or humerus, nerve injury, hypoxic injuries from oxygen deprivation, to potentially death. [ROA 242; Tr. 233:8-13.] He also testified that the mother faces "grave bodily harm" from unresolved shoulder dystocia. [ROA 250; Tr. 241:11-13.] However, the Plaintiff's expert pediatric neurologist tried to minimize the immediacy of the risk during the first five-ten minutes:

> [T]he risk wouldn't really begin for at least five minutes; meaning the risk that the unborn child was going to be deprived of a significant amount of oxygen wouldn't begin for five minutes or suffer injury from the lack of oxygen, wouldn't begin for five minutes. **** The risk of permanent brain damage doesn't occur until at least ten minutes...

[ROA 115; Tr. 106:1-12.]

Dr. Duchowny, the Defense expert pediatric neurologist, also opined that from a neurologic perspective, the Infant was in immediate risk of harm from brain injury during the ongoing shoulder dystocia situation due to a lack of oxygen. He testified that:

- "There's always a major concern for brain injury, because a baby that's locked into the birth canal is at significant risk for lack of oxygen and a brain injury." [ROA 911; Def. Ex. 31 - Duchowny Dep. 26:1-4.]
- "[O]xygen deprivation is a major crisis." [ROA 914; Def. Ex. 31 - Duchowny Dep. 40:25 – 41:1.]

In closing argument, Plaintiff's counsel essentially conceded that the issue of immediate threat was a question for the jury: "I'm not going to talk too much about immediate threat of harm. It depends on what the word immediate means to you." [ROA 828; Tr. 819:18-20.] Based on the divergent opinions outlined here, the Trial Court correctly denied a directed verdict and sent the question to the jury on proper instructions as to the applicable law. Accordingly, the judgment rendered on the jury's verdict for Defendant Dr. Maselli should be affirmed.

CONCLUSION

In the final analysis, this is a classic battle of the experts. The record contains conflicting expert opinions on each of the three elements: (1) whether the shoulder dystocia presented a genuine emergency situation when the Infant's head was delivered, (2) whether the Mother and/or Infant's condition was "not medically stable," and (3) whether the Mother and/or Infant was "in immediate threat of death" or "in immediate threat of serious bodily injury." Since it is undisputed that the Patient Mother was an established patient of Dr. Maselli's Group and the delivery was in an obstetrical suite, those conflicting opinions are more than sufficient to support the Trial Court's

decision to send the obstetric emergency exception to the jury under subsection §15-32-230(A) instead of subsection (B).

WHEREFORE, based on the foregoing, the Respondent respectfully submits that the Trial Court properly submitted the obstetric emergency exception, S.C. Code Ann. § 15-32-230(A), to the jury, and the Court should affirm the judgment entered on the jury's verdict in favor of the Respondents.

Respectfully submitted,

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The undersigned certified that this Final Brief complies with Rule 211(b), SCACR.

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