THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

Larry Hyman, Circuit Court Judge

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, — Respondents.

FINAL BRIEF OF APPELLANT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

REFERENCE MATERIAL

RULES AND STATUTES

STATEMENT OF ISSUES ON APPEAL

1. Whether the trial court erred by not determining S.C. Code Ann. § 15-32-230 failed as a matter of law.
2. Whether S.C. Code Section 15-32-230(a) is ambiguous and must be construed in accordance with standard principles of statutory construction.

STANDARD OF REVIEW

In an action at law, on appeal of a case tried by a jury, the appellate court may correct only errors of law. *Berberich v. Jack*, 392 S.C. 278, 709 S.E.2d 607 (2011), *Townes Assocs. v. City of Greenville*, 266 S.C. 81, 221 S.E.2d 773 (1976). An issue regarding statutory interpretation is a question of law. *S.C. Coastal Conservation Laugue v. S.C. Dep't of Health and Envtl. Control,* 390 S.C. 418, 425, 703 S.E.2d 246, 250 (2010). "Questions of statutory interpretation are questions of law, which the appellate court is free to decide without any deference to the court below." *Grier v. AMISUB of SC, Inc.* S.C. 532, 535, 725 S. E.2d 693, 695 (2012).

STATEMENT OF THE CASE

This is an obstetrical malpractice case involving an injury sustained by the minor appellant (hereinafter the "Child") at the time of his birth. Appellant Phillipa Smalling (hereinafter, the "Mother;" and collectively with the Child, the "Appellants") brought this action in her individual capacity and as Next Friend of the Child. Appellants allege that Dr. Lisa R. Maselli (hereinafter, the "OB"), and Carolina OB-GYN (hereinafter the "OB

Group;" and collectively with the OB, the "Respondents") mismanaged a complication of vaginal birth, thereby causing nerve injuries to the Child. (R. pp. 12-20)

Appellants filed the Summons and Complaint on October 12, 2016; and the case was designated as Civil Action Number 2016-CP-22-00863. *Id.* On November 11, 2016, Respondents answered with general denials and assertions of numerous affirmative defenses. These include the affirmative defense under S.C. Code Ann. § 15-32-230 which, *inter alia,* grants tort immunity to obstetricians acting on an emergency basis for certain of their patients, unless the patient proves he was grossly negligent. (R. pp. 21-30) Plaintiff filed an Amended Summons and Complaint on March 16, 2017, and it was answered on April 17, 2017 with no material defense added. (R. pp. 31-40)

Appellants moved on October 17, 2019 for partial summary judgment to preclude the statutory defense under § 15-32-320 on the basis that, properly construed, it does not apply to this case. (R. pp. 949-951) This motion was denied on December 17, 2018. (R. pp. 6-8)

The case went to trial against Respondents in the Georgetown County Court of Common Pleas beginning on April 1, 2019, with the Honorable Larry B. Hyman, Jr. serving as the trial judge for the majority of the trial. Trial started on a Monday and concluded that Friday, April 5, 2015. After the Respondents rested, Appellants moved for a directed verdict in their favor on the statutory defense, based in part on the inapplicability of the statute as a matter of law. (R. pp. 806-809) The Court determined the statute presented questions of fact for the jury. (R. p. 809)

During trial, a recently elected circuit court judge, the Honorable Bentley Price, had joined Judge Hyman at the bench to observe the trial proceedings. Judge Hyman invited

Judge Price to preside over the closing arguments. Judge Price sustained Respondents' motion to preclude Appellants from addressing in reply closing argument (1) the requirement that Appellants prove the OB was grossly negligent, if they concluded that Respondents had proven the statute applied; and (2) how the evidence proved that she was grossly negligent. (R. p. 858)

Over Appellants' objection, the court's jury charges included (1) S.C. Code Ann. Section 15-23-320 (A); and (2) the standard medical malpractice hindsight charge, without clarification that it applied only to the standard of care and not to statutory qualifiers of medical instability and immediate threat of death or serious bodily injury. (R. p. 712, line 23-p.713, line 5) The trial judge also overruled Appellant's alternative request to charge Subsection (B) of the statute, in light of his decision to charge Subsection (A). (R. p.711, line 7 – p. 712, line 10) Again, over Appellants' objection, the court submitted a jury verdict form which included the statutory defense. (R. p. 876)

The verdict form posed two initial questions whether Appellants had met their burden of proving ordinary negligence as a cause of the child's damages. (R. pp. 4-5) The verdict form then directed the jury to stop deliberations if the answer was "no," but to go to the next few questions concerning the statutory defense, if the answer to the first two questions was "yes." The next question asked whether, if the Respondents had met their burden of proving the statutory defense, Appellants had met their burden of proving the OB was grossly negligent. *Id.*

The jury began their deliberations at 4:03 pm on Friday, April 5, 2019. The jury foreman informed the judge that the jury had been unable to agree on the answer to the first two questions, but the jury had reached a decision on the rest of the questions and asked if

they could return a verdict on that basis. (R. pp. 881-890) Over Appellants' objection, the court agreed to accept their partial verdict. *Id.* Deliberations concluded at 6:25 pm.

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

After the jury was dismissed, Appellants moved orally for a new trial, which the judge denied at that time, before Appellants stated the grounds. (R. p. 895) Within ten days, on April 15, 2019, Appellants filed alternative written motions, for (1) a new trial and (2) relief under Rule 59(e), SCRCP, to alter or amend the oral ruling. (R. pp. 952-965) The judge agreed to hear all the motions in full. Following a hearing on June 27, 2019, the judge denied Appellants' motions. (R. pp. pp.1-3)

Appellants then timely served and filed their Notice of Appeal. (R. pp. 979-983) The amount involved in this appeal is over One Million Dollars.

STATEMENT OF FACTS

This is an obstetrical negligence claim involving allegations of negligence and other wrongdoing by the Defendant OB during the birth of the Child, which caused him to sustain severe and permanent injuries to his brachial plexus nerves on the right side. Brachial plexus nerves provide motor function to the muscles in the arm and shoulder area, as well as certain sensory functions. (R. pp. 91-92)

After learning she was pregnant, the Mother sought and received prenatal care from the OB Group. On April 27, 2013, the Mother was admitted to Georgetown Memorial

Hospital for labor and delivery. Upon her admission, the OB was responsible for managing Phillippa's labor and delivery. (R. pp. 897-904)

After the Child's head delivered, his top shoulder ("anterior" shoulder) did not deliver with normal and gentle guidance type of pulling ("traction"), signaling an obstetrical complication known as "shoulder dystocia." This complication results in a delay in delivery of the baby's body, usually caused, as in this case, by the top shoulder becoming lodged behind the mother's pubic bone in its passage through the birth canal. (R. pp.171-172)

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

The OB ordered the nurses to perform two external maneuvers in this delivery, one to change the Mother's leg position ("McRoberts") and the other intended to release the shoulder by indirect pressure on it by applying external pressure just above the Mother's pubic bone ("suprapubic pressure"). These, plus normal and gentle traction by the OB, did not release the top shoulder. The OB cut an episiotomy. The recognized reason to do so in this context is to provide more room for an obstetrician's hand(s) inside the birth canal for internal maneuvers. At that point three commonly used internal maneuvers were available for the OB to use to release the shoulder safely, with no increase in her traction on the baby's head or bending of his neck. Two involve rotation of the shoulder around the pubic

bone ("Rubin's" and "Woods"). The other involves sweeping the baby's bottom arm across his chest to deliver the bottom shoulder before the top one. ("posterior arm delivery method"). Despite having cut the episiotomy, the OB chose not to take advantage of any of these common safety procedures for which she was trained. Instead, she chose to try to release the top shoulder by manipulating the baby's head more forcefully. With the nurses performing suprapubic pressure according to her orders, the OB pulled the Child's head and neck out and down with increasing force. (R. pp. 94-95; pp. 117-122; pp. 184-186; pp. 207-216; p. 899; p. 902)

The Child was delivered approximately one minute after his head delivered. Unfortunately, he was delivered with traumatic injuries to the brachial plexus nerves on the right side of his neck. His right arm hung limp following his birth, paralyzed except for minimal movement of his fingers. (R. pp. 593-594; pp. 807-904) Three of his nerves have severe and devastating permanent damage. The child's C-5 and C-6 nerve roots are completely avulsed from his spinal cord; and the C-7 nerve root is partially avulsed. Avulsion means the nerve roots are actually pulled out from the spinal cord. This reduced the chance for him to obtain much surgical improvement, as there is no live nerve near the spinal cord to which the "downstream" nerve could otherwise have been reattached. He also had a large neuroma, encompassing the three injured nerves. That is like a large unhealed scab which further reduced his chance for surgical improvement. After multiple surgeries and extensive rehabilitation and therapy, the Childs's right shoulder and arm have improved somewhat, but he has significant impairments and disabilities which are permanent. These include, among others, loss of muscle mass and strength, disfigurement, and reduced range of motion in his right arm in all directions. He will never be able to

perform activities requiring two arms. He will have no use of his right arm except as a helper arm. He will suffer adverse effects on various other bodily functions, including gait, balance and skeletal symmetry. He will experience fewer career opportunities and reduced earning capacity as well as future medical expenses. (R. pp. 93-111; pp. 281-287; pp. 297-324; pp. 378-389; pp. 393-428)

ARGUMENT

I. THE TRIAL JUDGE ERRED IN NOT DETERMINING S.C. CODE 15-32-230 FAILED AS A MATTER OF LAW.

a. Introduction.

At issue in this appeal is the proper construction of S.C. Code Ann. § 15-32-230, which, *inter alia,* codified major changes in the common law regarding liability of obstetricians for injuries they cause during certain emergencies. The statute provides as follows:

> *Section 15-32-230.*
>
> *(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.

b. Subsection (B) preserves the right of established patients who had prenatal care to recover compensation for harm caused by obstetrical negligence during an emergency.

Appellants submit that the best starting point for construing the statute is Subsection (B). This Subsection is clear and unambiguous, before consideration of the Subsection (C) limitations. (B) grants qualified tort immunity "involving a medical malpractice claim arising out of obstetrical care rendered by a physician on an emergency basis...," if certain qualifying conditions are met. The qualifying conditions are (1) "the patient is not medically stable;" (2)(A) there is an "immediate threat of death" *or* (B) an "immediate threat of serious bodily injury;" and (3)(A) "when there is no previous doctor/patient relationship between the physician or a member of his practice with a patient *or (B)* the patient has not received prenatal care...." (Emphasis, numbering and lettering added.) Stated differently, Subsection (B) provides obstetricians immunity from liability for damages to unfavored patients caused by their obstetrical negligence, recklessness, willfulness and/or wantonness, whenever their obstetrical care is on an emergency basis, and when the obstetrician proves that the qualifying conditions are present. If a defendant obstetrician meets all these requirements, there is no physician liability absent the patient's proof that the obstetrician was "grossly negligent."

In altering tort liability of obstetricians *vis-à-vis* some but not all patients, the General Assembly deemed it important to distinguish patients with pre-existing

relationships *and* prenatal care from all others. Legislative intent was to immunize obstetricians from common law liability to the latter for all care provided on an emergency basis, except when the doctor was proven grossly negligent. Just as clearly, by distinguishing two categories of patients for Subsection (B) immunity, the General Assembly intended to preserve the right of favored (i.e., qualified as established patients who had prenatal care) patients to receive compensation for harm inflicted by obstetrical negligence during an emergency.

It is undisputed that Appellants had a previous relationship with Respondents' practice *and* received prenatal care. Thus, as a matter of law, Appellants are favored patients, and Respondents receive no relief under this emergency statute.

c. It is error to construe Subsection (A) to undermine the clear legislative intent expressed in Subsection (B) to preserve common law tort rights of established patients who had prenatal care.

The trial judge erred in his interpretation of S.C. Code Ann. § 15-32-230. By starting with a reading of Subsection (A), he missed the significance of Subsection (B) and applied Subsection (A) out of the context of the entire statute. Doing so thwarts legislative intent because it leaves Subsection (B) devoid of meaning or reason to exist. If Subsection (A) is applied to established patients who had prenatal care, this makes Subsection (B) superfluous.

In creating tort immunity which did not exist under the common law, S.C. Code Ann. § 15-32-230 plainly abrogated common law tort principles. "[S]tatutes in derogation of the common law are to be strictly construed." *Grier v. AMISUB of S.C., Inc., supra,* citing *Epstein v. Coastal Timber Co.*, 393 S.C. 276, 285, 711 S.E.2d 912, 917 (2011). Additionally, "[u]nder this rule, a statute restricting the common law will 'not be extended

beyond the clear intent of the legislature.'" *Id.* citing *Crosby v. Glasscock Trucking Co.*, 340 S.C. 626, 628, 532 S.E.2d 856, 857 (2000).

All subsections of 15-32-320 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.'").

As compared to Subsection (A), Subsection (B) is inoffensive to the common law, with respect to favored patients. To subsume Subsection (B) under Subsection (A) would disturb long-standing common law to an unnecessary and excessive extent. Strict construction requires that preservation of common rights of favored patients must prevail over any contrary construction of Subsection (A).

"The cardinal rule of statutory interpretation is to ascertain and effectuate the intention of the legislature." *Sloan v. Hardee,* 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007). "When a statute's terms are clear and unambiguous on their face, there is no room for statutory construction and a court must apply the statute according to its literal meaning." *Sloan v. Hardee, Id.* In interpreting a statute "(w)ords must be given their plain and ordinary meaning without resort to subtle or forced construction to limit or expand the statute's operation." Id. Viewed independently of other subsections, Subsection (B) is clear and unambiguous. The Court should apply its meaning without the forced construction that would result from Subsection (A)'s disregard of the distinctions (B) makes among patients.

Further, the "statute must be read as a whole and sections which are a part of the same general statutory law must be construed together and each one given effect. *S.C. State Ports Auth. V. Jasper Cnty.*, 368 S.C. 388, 398, 629 S.E. 2d 624, 629 (2006). Thus, the preservation of common law rights for favored patients under Subsection (B) must be given effect despite the absence of patient distinctions in Subsection (A).

"If the statute is ambiguous...Courts must construe the terms of the statute." *Town of Mt. Pleasant v. Roberts,* 393 S.C. 332, 713 S.E. 2d 278 (2011). The statutory language must be construed considering the intended purpose of the statute. Id. A court must not construe a statute in a way that leads to an absurd result or renders it meaningless. *Lancaster Cnty Bar Ass'n v. S.C. Comm'n on Indigent Def.,* 380 S.C. 219, 670 S.E. 2d 371 (2008). ("In construing a statute, this Court will reject an interpretation when such an interpretation leads to an absurd result that could not have been intended by the legislature".) These are well-established rules of statutory construction. See *Ranucci v. Crain,* 409 S.C. 493, 763 S.E.2d 189 (2014).

Subsection (B) addresses obstetrical care to the exclusion of all other types of primary or specialty care. Subsection (A) has no similar limitations. When Subsection (B) is applied to favored patients, their common law tort rights are preserved. Yet if broadly written Subsection (A) is construed to supplant narrowly written Subsection (B), those same rights would be curtailed or destroyed. That would be an absurd result, which cannot be allowed.

"[W]here there is one statute addressing an issue in general terms and another statute dealing with the identical issue in a more specific and definite manner, the more specific statute will be considered an exception to, or a qualifier of, the general statute and

given such effect." *Whiteside v. Cherokee Sch. Dist. No. One*, 311 S.C. 335, 340, 428 S.E.2d 886, 889 (1993) (citing *Wilder v. South Carolina Hwy Dep't.*, 228 S.C. 448, 90 S.E. 625 (1955)). By force of logic, the same principle should be applied to subsections of a statute which is in derogation of the common law, where the more specific subsection is less offensive to the common law.

"Under the 'last legislative expression' rule, where conflicting provisions exist, the last in point of time or order of arrangement, prevails. *Ramsey v. County of McCormick,* 306 S.C. 393, 397, 412 S.E.2d 408, 410 (1991); *Feldman v. S.C. Tax Comm'n*, 203 S.C. 49, 51, 26 S.E.2d 22, 24 (1943). As Subsection (B) follows (A), the former must prevail over the latter.

The legislature did not intend subsection (A) to be applied in isolation, to the exclusion of subsection (B). The General Assembly was purposeful in preserving recovery for ordinary obstetrical negligence where there has been a previous doctor/patient relationship *and* prenatal care. See *Ranucci* at 499-500. For these reasons the trial judge erred in failing to disallow the statutory defense as a matter of law.

II. S.C. CODE SECTION 15-32-230(A) IS AMBIGUOUS AND MUST BE CONSTRUED IN ACCORDANCE WITH STANDARD PRINCIPLES OF STATUTORY CONSTRUCTION.

a. The statute does not define "genuine emergency," "the patient is not medically stable," or "is" "in immediate threat;" and those phrases are ambiguous, in part, and must be construed to signify some factor other than conditions present in any medical emergency.

The statute does not define "genuine emergency," "the patient is not medically stable" or "is" "in immediate threat." A key issue in this appeal is interpretation of the

statute, an issue of law for this Court. Undefined terms in a statute must ordinarily be interpreted in accordance with their common and ordinary usage, if doing so conveys clear and definite meaning, consistent with legislative intent. Otherwise, traditional principles of statutory construction apply. For sake of brevity, these will not be repeated here, but are included in Argument I on pages 13-16, *supra*. The quoted phrases must be construed so that each word and phrase has meaning and purpose. The evidence which proves facts sufficient to represent a medical emergency will not suffice to prove any of the quoted phrases, or these phrases would be superfluous.

As noted below, one part of one of these phrases is clear. That is, "the patient" refers to "this patient," as opposed to any other patient, a generic patient, or the "genuine emergency" itself. The statute clearly implies that some patients like the Child may be medically stable, but others medically unstable, in the face of the same emergency.

b. There was no "genuine emergency" in this case as a matter of law.

Appellants have not located any definition of "genuine emergency." However, "medical emergency" has been defined as "[a] serious and unexpected situation involving illness or injury and requiring immediate action." *See* https://en.oxforddictionaries.com/definition/medical-emergency. "Emergency" has been defined as "an unforeseen combination of circumstances or the resulting state that calls for immediate action;" and "an urgent need for assistance or relief." *See* https://www.merriam-webster.com/dictionary/emergency.

The common features of these definitions are the urgency and immediacy of needed medical intervention to avoid serious adverse effects on one's medical state. Definition of the two words in the phrase, "genuine emergency," are obvious, yet under principles of statutory construction, "genuine emergency" is a term of art, though undefined in the

statute. "Genuine emergency" has to mean something different from "real emergency." Unless the legislature is worried about fake emergencies, the word "genuine" would otherwise be superfluous. The legislature must not be worried about fake emergencies, however, because Subsection (B) does not distinguish real emergencies from fake ones.

For an emergency to be "genuine" implies an emergency rarely encountered, or one for which a physician has not been trained to anticipate and manage with a regular pre-conceived plan of action. For example, despite shoulder dystocia being denoted an emergency in many obstetrical writings, it is not a "genuine" emergency for a board-certified obstetrician like the Respondent OB in this case, because shoulder dystocia is a well-recognized complication in that specialty. Obstetricians are trained from the beginning of residency (1) to anticipate the possibility of the complication arising in every vaginal delivery; (2) to make a management plan in advance; (3) to participate with labor and delivery nurses in shoulder dystocia drills; (4) to refrain from forceful pulling on the baby's head or bending down on his neck; and (5) to have command of customary procedures to safely resolve the dystocia. (R. pp. 175-181; pp. 543-546)

For a board-certified obstetrician like the Respondent OB in this case, shoulder dystocia is not a "genuine" emergency, as a matter of law. *See Amodeo v. Cumella*, 41 A.D. 3d 396 (N.Y. App. Div. 2007) (An emergency jury instruction was reversible error in a case involving alleged mismanagement of shoulder dystocia because shoulder dystocia occurs "with a fair amount of frequency," in "approximately one percent of all deliveries in the United States;" "obstetricians are generally prepared for the occurrence of shoulder dystocia;" there is "standard" training in this country about "procedures to be followed when confronted with a shoulder dystocia;" and "the obstetrician's management of such

cases becomes 'instinctive.'") Evidence of record confirms that the OB's training and experience is consistent with the reasoning of *Amodeo.* (R. pp. 543-546)

c. There was no "immediate threat" as a matter of law.

"Immediate" is sometimes defined as "now" or "instantaneous," without the passage of time. For example, the precise definition has been stated as follows: "occurring or accomplished without delay; instant;" "following or preceding without a lapse of time;" "of or relating to the present time or moment." *See* www.dictionary.com/browse/immediate. Yet other definitions are less precise, allowing for some degree of time lapse in the definition. To that extent, the word "immediate" is somewhat ambiguous.

The General Assembly's choice to use the word "is" in the phrase, "is"... "in immediate threat," provides two clues about the phrase's intended meaning. Use of the present tense, "is," suggests a strict definition of "immediate" would be proper, such as "now," "instantaneous," or "without a lapse of time." The word "is," in this context, also has a connotation of known fact. Assumption, possibility, speculation or fear of being in immediate threat are not encompassed within ambit of "is" "in immediate threat." Given a strict definition of "immediate," the Child was never in "immediate threat" as a matter of law.

d. There is no medical instability in this case as a matter of law.

Because Appellants have found no definition of the phrase "the patient is not medically stable," one reasonable approach is to analyze key words, "the patient," "is" and "stable." The significance of "the patient" is its requirement that the medical stability must be determined for *this patient,* not another patient, one with lack of stability or a bad

outcome, and certainly not a generic patient or emergency. As in the "immediate threat" discussion, "is" derives its importance in part from its present tense. The time to determine *this patient's* stability is in the present, not a risk of what might occur in the future. The word also suggests knowledge rather than possibility or other uncertainty. In the medical context, "stable" has been defined as "steady; not varying; resistant to change." *See* www.medilexicon.com/dictionary/84246. Merriam-Webster on-line does not provide a useful definition of "stable," but defines "stability," in pertinent part as: "the strength to stand or endure;" "the property of a body that causes it, when disturbed from a condition of equilibrium or steady motion to develop forces or moments that restore the original condition." *See* https://www.merriam-webster.com/dictionary/stability.

The legislature consciously included "is not medically stable" as a qualifier for tort immunity in a "genuine emergency." In so doing, they intended that phrase to have meaning other than the medical instability involved with any emergency. Medical instability within the meaning of the statute must be medical instability above and beyond that which is present in any emergency, or the phrase would be superfluous. In the context of this case, the phrase cannot refer to any changes in medical condition associated with labor and delivery itself or a shoulder dystocia complication. These types of medical instability are implicit risks in any labor and delivery and any shoulder dystocia, and are not focused, as the statute requires, on "the patient."

Respondents' futile effort to avail themselves of the statutory defense are illustrative. They relied on proof of medical instability potentially present in the progression of some generic shoulder dystocia but had no evidence of medical instability of *this patient* within the meaning of the statute. In fact, the only competent evidence of

the Child's medical stability status was his fetal heart monitor strips, Apgars and cord blood gases. (R. 897-904) All these measures were very good, demonstrating that the Child was "medically stable," well before the shoulder dystocia and was just as well when it resolved. As a matter of law, there was no "medical instability."

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

Under Subsection (A) 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 an emergency qualifies as a "genuine emergency" must be distinct from those criteria necessary to establish that a patient is "not medically stable;" and the criteria for meeting these conditions must be different from those used to determine if there is an "immediate threat" of death or serious bodily injury. One element cannot be a mere restatement of the others, as this would render statutory language superfluous and without purpose. *See Matter of Decker*, 322 S.C. 212, 417 S.E.2d 462 (1995) ("A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous …." 82 C.J.S. Statutes § 346.) Respondents' attempt to use evidence necessary to establish an emergency as itself representing sufficient proof of "genuine emergency," "not medically stable," and "in immediate threat" defies basic principles of statutory construction.

The statute as written, and as properly construed, recognizes that an emergency may or may not be genuine. If genuine, there may or may not be medical stability; and the

patient may or may not be in "immediate threat of death" or "serious bodily injury." There are approximately eight combinations of qualifiers either present or not. All or none may be present; any one or combination of two may be present. The statute does not apply unless there is separate and independent proof of each. The existence of one does not automatically encompass the other, and evidence which proves one is not competent to prove another. Each qualifier is unique as compared to the others, or it is superfluous.

Respondents conceived the presence of a shoulder dystocia emergency to be sufficient in itself to establish "genuine emergency," "not medically stable," and "in immediate threat." (R. p. 538; pp. 573-575; p. 676; p. 914) Though incorrect, this serves as a concise summary of one reason why Respondents' statutory defense must fail as a matter of law.

CONCLUSION

For the reasons stated, the judgment should be reversed, and the case remanded for a new trial.

Respectfully Submitted,

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CERTIFICATE OF COUNSEL

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

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