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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM ANDERSON COUNTY
Court of Common Pleas

R. Lawton McIntosh, Circuit Court Judge

Appellate Case No. 2021-001129

Anita and James Chabek, …….. Appellants,

v.

AnMed Health and Larry Davidson, MD, ……. Respondents.

APPELLANTS' RESPONSE TO THE AMICUS CURIAE BRIEF OF THE SOUTH CAROLINA HOSPITAL ASSOCIATION

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ARGUMENT

1. SCHA misstates the issue in question.

The South Carolina Hospital Authority ("SCHA") consistently portrays Ms. Chabek's informed consent claim as a demand for a physician to reveal all of his "mental health" or "personal health history" to a patient prior to surgery. (SCHA Br. at 1-6, 8). SCHA's (unsupported) forecast of peril for physicians, hospitals, and the South Carolina healthcare system is based on the notion that allowing the Chabeks' informed consent claim to go forward would impose a duty of "mandatory disclosure of personal health history" on physicians. (SCHA Br. at 5). But, a quick peek at the Record on Appeal shows that is not the issue the Chabeks raised or the issue on which the circuit court ruled. The actual issue is not Dr. Davidson's *history* but rather an "alcohol substance abuse relapse" that Dr. Davidson was "actively" facing, "in the midst of," and "currently dealing with" when Mrs. Chabek's surgery was contemplated and performed. Thus, SCHA assertion that a tort claim requiring "personal history" disclosures would invade the physician's privacy while offering the patient no additional material information skirts the narrow matter at issue here and adds nothing of value to the Court's analysis.

Throughout its brief, SCHA describes a far broader issue than this appeal actually raises. SCHA claims the issue is "whether a medical provider has an affirmative duty to disclosure the provider's own history of mental health, substance abuse, or alcoholism issues" to patient to obtained informed consent for medical procedure. (SCHA Br. at 1, 2). Later, SCHA speaks in even broader terms, claiming Ms. Chabek's claim would require disclosure of a physician's "personal health history." (SCHA Br. at 4, 5). SCHA seems especially concerned about a potential duty for a physician to disclose his medical history. (SCHA Br. at 6) (arguing Ms. Chabek seeks to impose broad duty for physicians to disclose "personal mental health and substance abuse histories");

(SCHA BR. at 8) (Ms. Chabek's claim would demand physicians make "exhaustive disclosure of past personal addictions").

This framing of the issue finds no support in the Chabeks' filings or the order on appeal. The factual basis for Ms. Chabek's informed consent claim is that Dr. Davidson was in the midst of an alcoholism relapse at the time of her spinal surgery. (R. p. 26 ¶¶ 6-8; R. p. 43 ¶¶ 6-8; R. p. 88 ¶¶ 6-8). At the time of the surgery, Dr. Davidson was drinking frequently and unable stop even though he knew he should. (R. p. 26 ¶ 7; R. p. 43 ¶ 7; R. p. 88 ¶ 7). Thus, the problem had nothing to do with Dr. Davidson's history but the fact that Ms. Chabek was never told Dr. Davidson was "in the midst of an alcohol substance abuse relapse and drinking most every day." (R. p. 27 ¶ 12; R. p. 44 ¶ 12; R. p. 89 ¶ 12). The fact section of the Chabeks' Notice of Intent and proposed Complaint summarized the matter as follows:

> Dr. Davidson never informed Mrs. Chabek that he ***was actively dealing with a substance abuse relapse*** so that she would have appropriate information to consent to her surgical procedure and/or have sufficient information to decide whether Dr. Davidson would be the best surgeon to perform her operation.

(R. p. 27 ¶ 13; R. p. 44 ¶ 13; R. p. 89 ¶ 13) (emphasis added). Ms. Chabek used precisely the same language to define the breach element of her informed consent claim. (R. p. 31 ¶ 30; R. p. 48 ¶ 30; R. p. 93 ¶ 30). The circuit court's ruling was based on Dr. Davidson's failure to disclose that he was "***currently dealing with*** an alcohol substance abuse relapse." (R. p. 17) (emphasis added).

Whether a spinal surgeon in the midst of an alcoholism relapse poses a material risk that he should disclose to his patient is a question SCHA's brief never considers. It is hard to fathom how Dr. Davidson telling Mrs. Chabek about his current, uncontrolled alcohol problem would "fail to enhance the informed consent process." (SCHA Br. at 2). Informed consent is designed to provide information to a patient that she does not know so she can make an intelligent choice whether to submit to surgery. Hook v. Rothstein, 281 S.C. 541, 547-48, 316 S.E.2d 690, 695 (Ct.

App. 1984). Dr. Davidson's alcohol problem was certainly information Ms. Chabek did not know, and there is no support offered for the notion that acquiring this information would have been irrelevant to Ms. Chabek's decision on the proposed spinal surgery.

In sum, SCHA asks the Court to consider this appeal through the lens of historical addictions "successfully managed" by a physician (SCHA Br. at 4). But, the actual risk Dr. Davidson allegedly failed to disclose was a current relapse he was not able to control. Rather than spin this case outward to extraneous matters, the Court's analysis should be limited to the claim raised in, and ruled on by, the circuit court.

2. SCHA's policy arguments are unsupported and unsupportable.

The bulk of SCHA's brief is a series of flawed policy arguments for which it presents no supporting evidence. Not a single citation of authority is offered for Arguments II through VI. (SCHA Br. at 4-7). Even when SCHA does reference medical industry literature, it does not offer an accurate or complete portrayal on the matter.

SCHA's primary argument is that the system governing South Carolina medical providers adequately protects patients from impaired physicians. (SCHA Br. at 2-3). SCHA cites the background check requirements a physician must meet before obtaining a medical license and an AMA ethics opinion urging providers to report impaired colleagues to authorities. Id. at 3 (citing Am. Med. Ass'n Ethical Op. 9.3.2). SCHA never explains how AMA's recommendation protects the right of a patient like Ms. Chabek to make an informed choice when an impaired physician continues practicing. More importantly, SCHA vastly overstates how effective this voluntary reporting system is at keeping impaired physicians from patients.

Even the AMA's own data casts serious doubt over SCHA's claim that the current system is "robust" and "adequate." According to data published in the *Journal of the American Medical*

Association ("*JAMA*") in 2010, more than one-third of all physicians surveyed did not even agree they had an ethical duty to report a "significantly impaired or otherwise incompetent" colleague.[1] The same *JAMA* report concluded that, while physicians support the notion of reporting impaired colleague to authorities in the abstract, "when faced with these situations, many do not report."[2] More than three hundred of the surveyed physicians reported having actually encountered an incompetent or impaired colleague, and nearly a third of those respondents took no action. These non-reporters explained they failed to act because they thought someone else would take care of the problem or because they did not think a report would do any good.[3] These startling statistics led researchers behind the survey to conclude there are "***important questions about the ability of medicine to self-regulate***."[4] Accordingly, there are substantial reasons to doubt SCHA's bald assertion that South Carolina's medical profession "adequately" protects patients through an physician monitoring system since even many physicians question its efficacy.

SCHA does offer one reference to AMA ethical guidelines, but there is a vast gulf between the policies SCHA advocates and the principles found in AMA publications. (SCHA Br. at 3). For example, SCHA argues disclosures related to substance abuse would harm physician-patient relationships. (SCHA Br. at 5) (arguing these disclosures would "distract" from the purpose of informed consent and both "confuse and/or overwhelm patients"). However, it is the substance abuse that causes harm, not disclosure of that abuse. AMA acknowledges substance abuse certainly harms a physician's ability to provide the medical services and patient communication his job

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[1] Katherine Harmon, "Many physicians fail to report incompetent or incapacitated colleagues," *Scientific American*, July 13, 2010.
[2] Catherine M. DesRoches, DrPH et al. "Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues," *Journal of American Medical Association*, 2010; 304(2): 187-93.
[3] Id. at 192.
[4] Id. (emphasis added).

demands. Am. Med. Ass'n Code of Medical Ethics, "AMA Ethical Opinion 9.3.2 (2016) (stating that substance abuse issues "can undermine physicians' ability to fulfill [fiduciary] obligation to patients").[5] It can also "put patients at risk, compromise physicians' relationships with patients" and "undermine public trust in the profession." Id. The AMA's acknowledgement of these dangers only further demonstrates that Dr. Davidson's alcoholism relapse was material information for his patients. Moreover, concealing substance abuse cannot be squared with the fiduciary obligation the same AMA opinion recognizes physicians owe to patients. Id.

SCHA also argues Dr. Davidson disclosing his current alcoholism relapse would have been "counterproductive." (SCHA Br. at 11). However, failing to make the disclosure denies patients like Ms. Chabek material information which, in turn, undermines her right to choose her own medical course—an interest the AMA has identified as a critical component of successful medical care. The AMA Code of Medical Ethics provides that a patient is always "entitled to choose [her] own physicians." Am. Med. Ass'n Code of Medical Ethics § 2.1.6, "Substitution of Surgeon" (2016). To effectively exercise that choice, Ms. Chabek was entitled to all material information about the proposed surgery itself as well as the individuals tasked with performing it.

For example, even if an attending physician disclosed all physiological risks of a proposed surgery, it would still be unethical for him to later substitute in a different provider to complete the procedure. Id. ("A surgeon who allows a substitute to conduct a medical procedure on his or her patient without the patient's knowledge or consent risks compromising the trust-based relationship of patient and physician"). That is true because the physician who proposes a surgical intervention to his patient has a duty to identify any other physician who will be part of the surgery, making the

[5] All AMA ethics documents cited in this section are included in their entirety in the Appendix attached to this brief.

patient aware of "all significant aspects" of the surgical team including the "*qualifications of clinicians*, services each clinician will provide, and billing arrangements." Am. Med. Ass'n Code of Medical Ethics § 2.3.6, "Surgical Co-Management" (2016) (emphasis added).

In this and in other ways, the AMA recognizes many physician-related circumstances (in addition to physiological risks of the procedure itself) must be disclosed to meet ethical standards. A separate provision of the AMA ethics code requires physicians to disclose a host of different things including "financial incentives" available to the physician. Am. Med. Ass'n Code of Medical Ethics § 11.2.4, "Transparency in Health Care" (2016). While financial incentives are certainly not a physiological risk or potential complication of the surgery itself, the AMA requires disclosure of these incentives or "***any other factors*** that could affect the patient's care." Id. (emphasis added); see also Allen v. Harrison, 374 P.3d 812, 816 (Okla. 2016) (A physician's duty is "not only to disclose what he intends to do, but to supply information which addresses the question of whether he should do it"). The broad disclosure duty the AMA advocates in this rule is guided by a simple principle: "Respect for patients' autonomy is a cornerstone of medical ethics." Am. Med. Ass'n Code of Medical Ethics § 11.2.4.

SCHA then suggests a physician disclosing his alcoholism relapse would harm the physician-patient relationship by chilling their communication. (SCHA Br. at 4). However, that position is antithetical to the AMA's rules on transparency. The AMA guideline on "Transparency in Healthcare" recognizes that "[p]atients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their healthcare." Am. Med. Ass'n Code of Medical Ethics § 11.2.4. Regarding patient safety, the AMA states that "physicians have an obligation to deal honestly with patients at all times." Am. Med. Ass'n Code of Medical Ethics § 8.6, "Promoting Patient Safety" (2016). A physician who conceals

his active alcoholism relapse from a patient staring down possible spinal surgery is not dealing honestly with the patient. More broadly, SCHA gets this point exactly backward. Incentivizing physicians to conceal material risks harms rather than helps physician-patient communications. Am. Med. Ass'n Code of Medical Ethics § 11.2.4. ("Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care").

In sum, SCHA's arguments are not only pegged to an issue this appeal does not raise, they also assert policy claims SCHA does not and cannot substantiate with any legal authority or medical literature. AMA ethics publications do not counsel physicians to conceal their active impairment from patients pondering serious surgery. Instead, the AMA repeatedly emphasizes patient autonomy and a physician's duty to be honest. The AMA does not restrict a physician's disclosure duties to physiological aspects of a proposed procedure but rather expressly requires disclosure of financial interests and "any other factors that could affect the patient's care."

3. SCHA incorrectly argues Ms. Chabek's claim would create a "new" or "expanded" duty.

Nearly every page of SCHA's brief suggests Ms. Chabek's claim would take South Carolina medical malpractice jurisprudence to some new, unexpected place by expanding the common law and creating a new legal duty. (SCHA's Br. at 2-7, 10-11) (opposing the "creat[ion]" of a "new" or "expanded" duty). But, SCHA misunderstands the nature of Ms. Chabek's claim. The duty at issue in an informed consent claim has been recognized in South Carolina for decades and the scope of that duty is equally well-defined by precedent. Hook, 281 S.C. at 547, 316 S.E.2d at 694-95; Hardee v. Bio-Medical Applications of S.C., Inc., 370 S.C. 511, 516, 636 S.E.2d 629, 631-32 (2006) (requiring disclosure of all "material risks involved in" and all "dangers associated with" proposed medical treatment). The only remaining question here is whether the duty was

breached and, like any other medical malpractice case, that is a question of fact a jury resolves after considering expert testimony. The circuit court erred by stepping in to answer this question of fact at the Notice of Intent stage of this litigation.

The danger here lies not in allowing Ms. Chabek's claim to go forward but in the circuit court's approach of dismissing it before it even got started. The effect of the circuit court's order was to rule, as a matter of law, that a spinal surgeon's current, uncontrolled alcoholism relapse is not material information a patient must be permitted to consider before agreeing to a potentially life-altering medical procedure. The circuit court made that ruling despite an expert orthopedic surgeon's sworn statement that such information was material and any reasonable physician would have disclosed it. (R. p. 168 ¶¶ 2-3). In one fell swoop, the circuit court plucked from the universe of material risks all potential dangers except the potential physiological complications of a proposed medical procedure. In asking for that order to be affirmed, Respondents would have the Court turn that ruling into precedent.

That request puts the court in the uncomfortable position of stepping out of its legal arena to answer what is intrinsically a medical question. Hook, 281 S.C. at 551, 316 S.E.2d at 697 ("the decision as to risk disclosure is a medical question"). The practice of reasonable physicians dictates the standard of care for medical malpractice cases, and litigants' experts debate both what that standard of care entails and whether a defendant doctor breached it. Hoard ex rel. Hoard v. Roper Hosp., Inc., 387 S.C. 539, 546, 694 S.E.2d 1, 5 (2010). There is no *legal* basis for a court to step in at the Notice of Intent stage of a medical malpractice suit, disregard an unopposed expert affidavit, and rule on the materiality of dangers posed by a surgeon's impairment. Respondents and their amici certainly do not offer one. SCHA asks the Court to base its ruling on a patchwork of non-legal considerations ranging from hospital administrative procedures (SCHA Br. at 5-6) to

the operation of the South Carolina Board of Medical Examiners' disciplinary process (Id. at 2-3) to the general attractiveness of the South Carolina job market for future medical school graduates. (Id. at 6-7). The peril in this appeal lies in accepting Respondents' invitation to delve into complicated medical policy and come out on the other side with a general rule that stands at odds with a patient's right to choose—the precise interest that has animated the informed consent doctrine since its inception. Hook, 281 S.C. at 547-48, 316 S.E.2d at 695.

The Court can resolve this appeal without any of those complications by considering Ms. Chabek's informed consent claim just as it would any other medical malpractice suit. Hook, 281 S.C. at 550, 316 S.E.2d at 696 ("An informed consent action is no different from any other action for professional negligence"). Ms. Chabek has alleged a breach (R. p. 30-31 ¶¶ 29-33) of Dr. Davidson's duty to disclose all "material risks involved in" and all "dangers associated with" the surgery offered to her when he failed to disclose his current, uncontrolled alcoholism relapse. Hook, 281 S.C. at 547, 316 S.E.2d at 694-95; Hardee, 370 S.C. at 516, 636 S.E.2d at 631-32. Even at the Notice of Intent stage, Ms. Chabek has supported her allegations with an expert affidavit stating that a reasonable physician would have told Ms. Chabek about this issue. (R. p. 168 ¶¶ 2-3). Accordingly, Dr. Davidson's potential liability remains a viable issue to be challenged by Dr. Davidson's experts and then either accepted or rejected by the factfinder.

Using that approach, the Court would avoid imposing a rule defining the materiality of risks for a surgeon to disclose or excluding whole categories of crucial information from that definition. The Court would also preserve the normal procedure of resolving disputes over the reasonableness of a physician's conduct—i.e. presentation of competing evidence resolved by a properly instructed jury. Finally, the Court would keep South Carolina from becoming a state that says to its citizens they have no right to know whether their spinal surgeon is impaired by alcohol

abuse and no remedy for him taking away their right to make an informed choice about a serious medical procedure.

CONCLUSION

Based on the arguments above, Appellants respectfully request the Court reject SCHA's arguments. Since SCHA misstates the matter at issue in this appeal, many of its objections to Ms. Chabek's suit do not match the claim she is actually making. Moreover, SCHA's policy arguments are unsupported and, even when they do reference a single AMA ethics document, they fail to accurately portray what the AMA has said about a physician's broad disclosure duty. Finally, the SCHA improperly invites the Court to stray from the law to make a ruling on matters of medical policy that is not required to fully and fairly resolve this appeal.

Respectfully submitted,

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September 5, 2023

Appendix

- AMA Code of Medical Ethics § 2.1.6
- AMA Code of Medical Ethics § 2.3.6
- AMA Code of Medical Ethics § 8.6
- AMA Code of Medical Ethics § 9.3.2
- AMA Code of Medical Ethics § 11.2.4

Code of Medical Ethics

2.1.6 Substitution of Surgeon

Topic: Code of Medical Ethics	**Policy Subtopic:** Opinions on Consent, Communication & Decision Making (2.1 Informed Consent & Shared Decision Making)
Meeting Type: NA	**Year Last Modified:** 2017
Action: NA	**Type:** Code of Medical Ethics
Council & Committees: NA	

Patients are entitled to choose their own physicians, which includes being permitted to accept or refuse having an intervention performed by a substitute. A **surgeon** who allows a substitute to conduct a medical procedure on his or her patient without the patient□s knowledge or consent risks compromising the trust-based relationship **of** patient and physician.

When one or more other appropriately trained health care professionals will participate in performing a surgical intervention, the **surgeon** has an ethical responsibility to:

(a) Notify the patient (or surrogate if the patient lacks decision-making capacity) that others will participate, including whether they will do so under the physician's personal supervision or not.

(b) Obtain the patient's or surrogate's informed consent for the intervention, in keeping with ethical and legal guidelines.

AMA Principles of Medical Ethics: I,II,IV,V

*The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards **of** clinical practice or rules **of** law.*

Policy Timeline

Issued: 2016

Code of Medical Ethics

2.3.6 Surgical Co-Management

Topic: Code of Medical Ethics	**Policy Subtopic:** Opinions on Consent, Communication & Decision Making (2.3 Communication with Patients)
Meeting Type: NA	**Year Last Modified:** 2017
Action: NA	**Type:** Code of Medical Ethics
Council & Committees: NA	

Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:

(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.

(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.

(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.

(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.

(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.

(f) Employ appropriate safeguards to protect patient confidentiality.

(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.

(h) Engage another caregiver based on that caregiver□s skill and ability to meet the patient□s needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.

(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

AMA Principles of Medical Ethics: I,II,IV,V,VI

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Policy Timeline

Issued: 2016

Code of Medical Ethics

8.6 Promoting Patient Safety

Topic: Code of Medical Ethics	**Policy Subtopic:** Opinions on Physicians & the Health of the Community
Meeting Type: NA	**Year Last Modified:** 2017
Action: NA	**Type:** Code of Medical Ethics
Council & Committees: NA	

In the context of health care, an error is an unintended act or omission or a flawed system or plan that harms or has the potential to harm a patient. Patients have a right to know their past and present medical status, including conditions that may have resulted from medical error. Open communication is fundamental to the trust that underlies the patient-physician relationship, and physicians have an obligation to deal honestly with patients at all times, in addition to their obligation to promote patient welfare and safety. Concern regarding legal liability should not affect the physician□s honesty with the patient.

Even when new information regarding the medical error will not alter the patient□s medical treatment or therapeutic options, individual physicians who have been involved in a (possible) medical error should:

(a) Disclose the occurrence of the error, explain the nature of the (potential) harm, and provide the information needed to enable the patient to make informed decisions about future medical care.

(b) Acknowledge the error and express professional and compassionate concern toward patients who have been harmed in the context of health care.

(c) Explain efforts that are being taken to prevent similar occurrences in the future.

(d) Provide for continuity of care to patients who have been harmed during the course of care, including facilitating transfer of care when a patient has lost trust in the physician.

Physicians who have discerned that another health care professional (may have) erred in caring for a patient should:

(e) Encourage the individual to disclose.

(f) Report impaired or incompetent colleagues in keeping with ethics guidance.

As professionals uniquely positioned to have a comprehensive view of the care patients receive, physicians must strive to ensure patient safety and should play a central role in identifying, reducing, and preventing medical errors. Both as individuals and collectively as a profession, physicians should:

(g) Support a positive culture of patient safety, including compassion for peers who have been involved in a medical error.

(h) Enhance patient safety by studying the circumstances surrounding medical error. A legally protected review process is essential for reducing health care errors and preventing patient harm.

(i) Establish and participate fully in effective, confidential, protected mechanisms for reporting medical errors.

(j) Participate in developing means for objective review and analysis of medical errors.

(k) Ensure that investigation of root causes and analysis of error leads to measures to prevent future occurrences and that these measures are conveyed to relevant stakeholders.

AMA Principles of Medical Ethics: I,II,III,IV,VIII

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Policy Timeline

Issued: 2016

Code of Medical Ethics

9.3.2 Physician Responsibilities to Impaired Colleagues

Topic: Code of Medical Ethics	**Policy Subtopic:** Opinions on Professional Self-Regulation (9.3 Physician Wellness)
Meeting Type: NA	**Year Last Modified:**
Action: NA	**Type:** Code of Medical Ethics
Council & Committees: NA	

Providing safe, high-quality care is fundamental to physicians fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions including physical disability, medical illness, and substance use can undermine physicians ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians relationships with patients, as well as colleagues, and undermine public trust in the profession.

While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.

(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.

(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency.

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Policy Timeline

Issued: 2016 Amended: 2021

Code of Medical Ethics

11.2.4 Transparency in Health Care

Topic: Code of Medical Ethics	**Policy Subtopic:** Opinions on Financing & Delivery of Health Care (11.2 Health Care Organizations & Physician Practice)
Meeting Type: NA	**Year Last Modified:** 2017
Action: NA	**Type:** Code of Medical Ethics
Council & Committees: NA	

Respect for patients autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their **health care**. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives; and formularies, guidelines or other tools that influence treatment recommendations and **care**. Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of **care**.

Although **health** plans and other entities may have primary responsibility to inform patient-members about plan provisions that will affect the availability of **care**, physicians share **in** this responsibility.

Individually, physicians should:

(a) Disclose any financial and other factors that could affect the patient s **care**.

(b) Disclose relevant treatment alternatives, including those that may not be covered under the patient s **health** plan.

(c) Encourage patients to be aware of the provisions of their **health** plan.

Collectively, physicians should advocate that **health** plans with which they contract disclose to patient-members:

(d) Plan provisions that limit **care**, such as formularies or constraints on referrals.

(e) Plan provisions for obtaining desired **care** that would otherwise not be provided, such as provision for off-formulary prescribing.

(f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest **in** physicians treatment recommendations.

AMA Principles of Medical Ethics: I,II,III,V,VI

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Anita and James Chabek, …….. Appellants,

v.

AnMed Health and Larry Davidson, MD, ……. Respondents.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that, on September 5, 2023, he served Respondents' counsel with Appellants' Response to the Amicus Curiae Brief of the South Carolina Hospital Association at the email addresses listed below pursuant to Rule 262(c)(3), SCACR and Section (d)(1) of the South Carolina's Supreme Court's August 25, 2021 order (Order No. 2021-08-25-02):

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Tue 9/5/2023 4:42 PM

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Cc:Jay Wright <jaywright@mcgowanhood.com>

1 attachments (254 KB)

A. Chabek--Response to SCHA's Amicus Brief COMPLETE PDF.pdf;

Counsel:

I am attaching Appellants' Response to the SCHA's Amicus Curiae Brief that is being electronically filed today with the Court of Appeals. Pursuant to Rule 262(c)(3), SCACR and Section (d)(1) of the South Carolina Supreme Court's August 25, 2021, order (Order No. 2021-08-25-02), please consider this email as service for the Response.

Thanks,

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