RECEIVED
Sep 08 2023
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 AMERICAN MEDICAL ASSOCIATION AND THE SOUTH CAROLINA MEDICAL ASSOCIATION

Jay F. Wright
McGowan, Hood & Felder, LLC
135 Edinburgh Court, Suite 202
Greenville, SC 29607
(864) 252-4406
jaywright@mcgowanhood.com

Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
jcalloway@mcgowanhood.com

Attorneys for Appellants

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Case Law

South Carolina cases

Other Jurisdictions

American Medical Association ("AMA") Publications

Secondary Sources

ARGUMENT

1. The Associations' "balancing" analysis ignores the most important interest in informed consent cases.

The American Medical Association ("AMA") and South Carolina Medical Association's ("SCMA") (collectively, the "Associations") overarching argument is that Ms. Chabek's informed consent claim would upset the delicate "balance" already in place to address impaired physicians. (Associations' Br. at 2, 9). Notably, this argument ignores a patient's interest in making a truly informed choice regarding her healthcare. That interest cannot be overlooked and does not take a backseat to any other interest because it is the animating force for the informed consent doctrine.

South Carolina's informed consent doctrine for medical malpractice claims has been developed by nearly forty years of state appellate precedent and a rich history of common law governing a physician's communications with her patient. This broad swath of legal authority elevates a patient's right to self-determination over all other interests at play in medical decision making. No right is more "sacred" and no interest more "carefully guarded" than a patient's power to choose what invasive medical procedures she elects to endure and what attendant risks she is willing to accept.[1] Any analysis of the doctrine's parameters and application of its terms is complete only by considering how, as summarized below, South Carolina law empowers patients to chart their own medical course by demanding physicians provide all information needed to make informed choices.

South Carolina applies a robust informed consent doctrine to protect its citizens' most important interests. The state's first official recognition of informed consent grounded the doctrine in "the patient's right to exercise control over his or her own body by deciding for himself or

[1] Harvey v. Strickland, 350 S.C. 303, 309, 566 S.E.2d 529, 533 (2002) (quoting Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

herself whether or not to submit to the particular procedure." Hook v. Rothstein, 281 S.C. 541, 547-48, 316 S.E.2d 690, 695 (Ct. App. 1984) (citing Sard v. Hardy, 379 A.2d 1014, 1019 (Md. 1977)). Hook identified both the protected interest in informed consent cases and the means by which tort law protects that interest. A patient must be permitted to "decide[] for . . . herself" on a proposed surgery or diagnostic test, and she can only effectively exercise this right if all facts material to a proposed medical intervention are provided before she makes her decision. Id.

a. Informed consent protects a patient's inherent rights to autonomy and self-determination.

Preserving a patient's freedom to make the final call over medical decisions is a direct application of an individual's broader right to control her own affairs. That right must remain nearly inviolate, taking precedence over any other concerns arising in a medical exam room. Harvey, 350 S.C. at 309, 566 S.E.2d at 533 (2002) (quoting Botsford) ("no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person")). The body is an individual's most fundamental "possession" and each mature and competent person must retain "control" over its destiny. Harvey, 350 S.C. at 309, 566 S.E.2d at 533 (quoting Schloendorff v. New York Hosp., 211 N.Y. 125, 105 N.E. 92, 93 (1914) (Cardozo, J.) ("every human being of adult years and sound mind has a right to determine what shall be done with his own body . . .")). Thus, informed consent ultimately protects the fundamentally American and inherently human interests in personal autonomy and bodily "integrity." Harvey, 350 S.C. at 310, 566 S.E.2d at 533 (citing In re Duran, 769 A.2d 497 (Pa. Super. 2001)).

South Carolina is not alone in prioritizing patient control and individual choice when requiring physicians to disclose information prior to surgery. Common law rules governing physician-patient communications are designed to further "important interests of dignity, self-

determination, autonomy, and privacy." Matter of Nora D., 485 P.3d 1058, 1065 (Alaska 2021). Medical providers do not preserve a patient's dignity—the belief that a person is worthy of honor and respect—by denying the patient information needed to make an informed choice. Commentators note the legal requirement of consent, in medial and other contexts, is simply an expression of America's value of the individual. Each person "should be the author of her own undertakings" and "a genuine respect for her dignity requires a broad deference to her choices." Peter H. Schuck, "Rethinking Informed Consent," 12 YALE L. J. 899, 900 (Jan. 1994).

The value of self-determination is repeatedly identified as informed consent's core animating force. Schrieber by Krueger v. Physicians Ins. Co. of Wis., 579 N.W.2d 730, 734 (Wis. App. 1998) (citing In re Guardianship of L.W., 482 N.W.2d 60, 65 (Wis. 1992)); Hidding v. Williams, 578 So.2d 1192, 1194 (La. App. 1991); see also Armstrong v. State, 989 P.2d 364, 381 (Mont. 1999) ("Few matters more directly implicate personal autonomy and individual privacy than medical judgments affecting one's bodily integrity and health"). A physician who values the autonomy of his patient to make an informed choice whether to undergo surgery not only adheres to a legal command, he also respects his broader obligations to the patient, the medical system, and society at large. Schrieber, 579 N.W.2d at 734 ("basic to the informed consent doctrine is that a physician has a legal, ethical and moral duty to respect patient autonomy . . .").[2]

Some courts describe a patient's self-determination interest as the "right to choose" while others speak in starker terms, describing the absence of informed consent as deprivation of an individual's "sovereignty." Turner v. Children's Hosp., Inc., 602 N.E.2d 423, 431 (Ohio App.

[2] See also Schuck, 12 YALE L. J. at 921 (arguing that a physician's duty to disclose "underscores the purpose of informed consent proper, which is not simply to provide information to empower the patient to protect her own interests, but also, and perhaps more important, to further the physician's responsibility to place the patient's interests above her own").

1991); Bronneke v. Rutherford, 89 P.3d 40, 44 (Nev. 2004) (citing Smith v. Shannon, 666 P.2d 351, 354 (Wash. 1983) ("the doctrine of informed consent is premised upon patient sovereignty and the patient's ability to intelligently govern the treatment of his body"). To ensure a patient's sovereignty, "[t]he law will not allow a physician to substitute his own judgment, no matter how well founded, for that of his patient." Armstrong, 989 P.2d at 383 (quoting Collins v. Itoh, 503 P.2d 36, 40 (Mont. 1972)). A competent patient must be afforded the sovereign decision to say "yes" or "no" to a procedure because it is the patient, not the physician, who will have to live with the harm caused by any undisclosed risk. Armstrong, 989 P.2d at 381 (quoting Andrews v. Ballard, 498 F. Supp. 1038, 1047 (S.D. Tex. 1980) ("It is the individual, and no one else, who lives with the pain and disease")).

Ensuring a patient receives informed consent also furthers the patient's privacy interests. Id. (noting that an individual's medical decisions are, "to an extraordinary degree, intrinsically personal")). South Carolina, like many other states, recognizes medical decision making as a matter of the individual's private life, and the individual's sovereignty in such matters is part of "the very bedrock on which this country was founded." Harvey, 350 S.C. at 310, 566 S.E.2d at 533 (quoting Wons v. Public Health Trust, 500 So.2d 679, 687 (Fla. App. 1987)). Finally, research suggests a robust informed consent doctrine has utilitarian benefits in the form of improved patient outcomes. *See e.g.*, Nadia N. Sawicki, "Modernizing Informed Consent: Expanding the Boundaries of Materiality, 2016 U. Ill. L. Rev. 821, 827 (2016) (concluding that a physician who provides all material information to his patients "promotes their welfare by leading to objectively better choices").

In sum, South Carolina's informed consent doctrine was created to protect patients' power to choose for themselves the course of their medical treatment. The common law that birthed South

Carolina's approach to informed consent recognizes a patient's health is a uniquely personal matter and submission to invasive medical procedures strikes at the heart of an individual's sovereign right to control her own affairs. Thus, when there are material risks associated with a proposed medical intervention, the informed consent doctrine aims to ensure it is the patient's decision alone whether to assume that risk by going forward with the procedure.

b. Only a robust disclosure of material risks empowers a patient to make an informed choice.

As this Court recognized when adopting the doctrine, informed consent is designed to keep the patient in control of whether a potentially dangerous medical procedure goes forward by making it her choice. Hook, 281 S.C. at 547-48, 316 S.E.2d at 695. South Carolina law, and substantial persuasive authority, also show that a patient's power to choose is only meaningful if her physician provides all material information related to the proposed procedure before the patient is asked to submit to it.

Nearly every choice we make carries the potential to produce a good or bad result. Choosing wisely among courses of action demands an individual weigh each alternative's risks/rewards before making a selection and hoping for a positive outcome. Most times, choosing is made easier because the risks assumed by our choice are both overt and easily understood. Motorists get behind the wheel by reasoning the importance of their destination is worth the well-known risk of a collision along the way. Business travelers book a flight because the real, if slight, risk of a crash is outweighed in their mind by the convenience of air travel.

But, an individual's power to choose faces unique challenges in the medical context. Weakened by an ailment and anxious over the future, a patient seeks out a physician for his skill, judgment, and fidelity to the patient's health goals. Inevitably, the treatment options will present medical complexities no layman can fathom. Thus, the risks of proceeding to surgery are neither

overt nor easily understood. Yet, for the reasons discussed above, the law demands this remain the patient's choice. The informed consent doctrine is what prevents this situation from becoming untenable either because the patient—limited by her ignorance—is forced to make a merely hopeful decision or to reluctantly delegate her choice to the physician. A leading decision from Maryland's top court (which Hook used to ground South Carolina's iteration of the doctrine), describes the dilemma that informed consent seeks to solves:

> Whatever its source, the doctrine of informed consent takes full account of the probability that unlike the physician, the patient is untrained in medical science, and therefore depends completely on the trust and skill of his physician for the information on which [s]he makes [her] decision.

Sard v. Hardy, 379 A.2d at 1019 (citing Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972)).

Accordingly, under South Carolina law, a physician's disclosure duty arises from and is guided by his unique responsibility to empower the patient to confront a choice her personal knowledge and experience alone cannot competently make. Cooper v. U.S., 903 F. Supp. 953, 956 (D.S.C. 1995) (physician must provide sufficient information so that the patient may "make an intelligent choice about his or her own health care"). The physician must tell his patient everything required to make her evaluation of the proposed procedure "intelligent" (guided by the relevant medicine) and "informed" (made in light of an understanding of all conditions in the operating room that could sway her choice). Sard, 379 A.2d at 1020.

This view of the purpose and scope of a physician's disclosure duty dates back to the very first informed consent decision. *Id.* (quoting Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 317 P.2d 170, 181 (Cal. App. 2d 1957) (generally considered the first appellate ruling to discuss a physician's disclosures as a duty to provide "informed consent"). Salgo reasoned that, in practice, informed consent must mean a physician "place[s] the welfare of his patient above all else" by providing "full disclosure of facts necessary to an informed consent." 317 P.2d at 181. The

physician faces liability anytime he "withholds any facts which are necessary to form the basis of an intelligent consent." Id.

This view also inheres to the very nature of the term "informed consent." An uninformed patient left to flounder over the prospect of surgery can give her physician an *answer* about whether to go forward, but she cannot in any real sense provide "*consent*" for that procedure. Brown v. Dibbell, 582 N.W.2d 134, 136 (Wis. App. 1998) (citing Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) ("True consent is the informed exercise of choice, and entails the opportunity to knowledgeably evaluate the available options and attendant risks"); see also Geler v. Akawie, 818 A.2d 402, 417 (N.J. Super. 2003) ("the exercise of choice depends on a foundation of adequate information"). Even the dictionary defines "informed consent" to be an individual's "agreement to allow something to happen" but only if "made with full knowledge of the risks involved and the alternatives." Wuerz v. Huffaker, 42 S.W.3d 652, 656 (Mo. App. 2001) (quoting Black's Law Dictionary 300 (7th ed. 1999)).

Therefore, a physician's duty to disclose material information to patients prior to surgery must be substantially robust to empower the patient to make an intelligent and informed choice about whether to proceed. Anything less betrays the trust a layman patient must place in her physician and prevents the patient from meaningfully exercising her right to determine which risks she is willing to assume.

2. The Associations fail to properly analyze the relevant privacy interests.

The Associations' other major argument seems to be that a physician's privacy interests must exempt him from a responsibility to inform an individual he voluntarily took on as a patient about the serious risk posed by the physician's alcohol abuse during a surgery he recommends the patient undergo. (Associations' Br. at 4, 10-11). That argument is problematic for several reasons.

First, as discussed above, the Associations' argument gives no consideration to a patient's right to make an informed choice which many courts have identified as part of her inherent right to privacy. Second, the Associations largely discuss privacy concerns that are not implicated here. They cite protections afforded "substance use disorder treatment" information (Associations' Br. at 11), but Ms. Chabek's informed consent claim never suggests she was entitled to the contents of Dr. Davidson's treatment records. 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).[3]

Third, the Associations do not discuss what constitutes a private matter under South Carolina law. The notion of "private affairs" is limited to "facts in which there is no legitimate public interest." Snakenberg v. Hartford Cas. Ins. Co., Inc., 299 S.C. 164, 170-71, 383 S.E.2d 2, 6 (Ct. App. 1989). The South Carolina Supreme Court has held that "public interest . . . is great" in preventing a physician from treating patients while under the influence of drugs. State Bd. of Med. Exam'rs v. Fenwick Hall, Inc., 308 S.C. 477, 419 S.E.2d 222 (1992). Similarly, South Carolina law limits "private" affairs to those aspects of an individual that he "normally expects will be free from exposure to the" opposing party. Snakenberg, 299 S.C. at 171, 383 S.E.2d at 6. Here,

[3] Even if substance abuse treatment had been part of the claim, the Associations fail to acknowledge that neither federal nor state law protections for these documents are absolute. See e.g. 42 U.S.C. § 290dd-2(b)(2)(C) (permitting disclosure of substance abuse treatment records when court finds "good cause"); S.C. Code Ann. § 44-22-100(A)(2) (allowing court order for disclosure where failure to disclose is "contrary to the public interest").

Appellants' expert states that a reasonable physician in Dr. Davidson's shoes would not have considered his current alcoholism relapse to be private relative to Ms. Chabek because a reasonable physician would have in fact disclosed the relapse to her. (R. p. 168 ¶¶ 2-3).

Thus, while the Associations ground their argument in privacy concerns, they do not properly weigh any of the privacy interests at play here. They ignore a patient's privacy-based right to have the information necessary to make an informed choice. They also overstate a physician's privacy interests by focusing on substance abuse treatment information that is not relevant here and by failing to heed South Carolina's definition of what counts as private information.

3. The Associations incorrectly argue Ms. Chabek's claim would create a "new" or "expanded" duty.

The Associations suggest this appeal seeks to create "new law and [a] new duty." (Associations' Br. at 4). However, Ms. Chabek's claim is based on deep-rooted informed consent law. 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.

A physician's duty to disclose has been established in South Carolina since Hook adopted the informed consent doctrine in 1984. 281 S.C. at 547, 316 S.E.2d at 694 (physician "has a duty to disclose to a patient of sound mind . . ."). The scope of that duty is just as firmly established. The physician's duty extends to all "material risks involved in the procedure," defined elsewhere as all "attendant risks and effects" and all "dangers associated with medical treatment." Id. 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). South Carolina law also recognizes materiality is a reasonableness standard determined from the perspective of what a reasonable physician would have disclosed under the circumstances. Hook, 281 S.C. at 548, 316 S.E.2d at 695; Melton v. Medtronic, Inc., 389

S.C. 641, 656, 698 S.E.2d 886, 894 (Ct. App. 2010).[4] Expert testimony is generally required to determine what a reasonable physician would disclose and an expert's testimony is generally sufficient to create a question of fact for trial. Hook v. Rothstein, 275 S.C. 187, 188-89, 268 S.E.2d 288, 289 (1980) (finding expert affidavits from defendant physician's experts created question of fact on materiality question).

Since the duty and its scope have been defined by South Carolina courts, case-specific materiality disputes go to the breach element of the plaintiff's medical malpractice claim. Whether a medical malpractice defendant breached the standard of care is a jury question. Fields v. Reg'l Med. Ctr. Orangeburg, 363 S.C. 19, 34, 609 S.E.2d 506, 513 (2005) (since parties presented conflicting expert testimony, "[w]hether Physician's actions met the requisite standard of care was a question for the jury"); Turner v. Med. Univ. of S.C., 430 S.C. 569, 586, 846 S.E.2d 1, 9 (Ct. App. 2020) (reversing directed verdict because "it would be reasonably conceivable for a jury to find [defendant doctor] breached the standard of care"). Informed consent actions are medical malpractice claims and subject to the same rule. Hook, 281 S.C. at 551, 316 S.E.2d at 697 (citing Woolley v. Henderson, 418 A.2d 1123, 1130 (Me. 1980)).[5]

A court declaring a surgical danger to be immaterial as a matter of law would step outside its defined role and into a complex field of medical analysis. Since materiality turns on the actions

[4] South Carolina's adoption of the "professional standard"—i.e. judging materiality from a reasonable physician's perspective—does not mean the reasonable patient's expectations for disclosure are irrelevant. Hook, 281 S.C. at 562 n. 5, 316 S.E.2d at 703 at n. 5 (rejecting challenge to jury charge that read in part, "A risk is material if a reasonable person, in the patient's position, would attach significance to it in deciding whether or not to submit to the proposed treatment or procedure").

[5] See also Hurley v. Kirk, 398 P.3d 7, 9 (Okla. 2017) (citing Scott v. Bradford, 606 P.2d 554, 558 (Okla. 1979) ("[n]o bright line rule exists separating the material from the immaterial; it is a fact question"); Wilkinson v. Vesey, 295 A.2d 676, 689 (R.I. 1972) ("Liability should be imposed only if the trier of fact finds the physician's communications to be unreasonably inadequate").

of an objectively reasonable doctor and is informed by often conflicting expert testimony, South Carolina law leaves resolution of the matter to the factfinder. In the traditional medical malpractice case, a South Carolina court would not declare that, despite a patient's expert testimony, the defendant's selection of medication or surgical instrument during a procedure could not, as a matter of law, breach the standard of care. The same rule should apply to informed consent cases. A court, considering a record with contrary expert testimony, should not declare a surgeon's condition to be immaterial as a matter of law. See Hook, 281 S.C. at 552, 316 S.E.2d at 697 (discouraging courts from "play[ing] at the game of being doctor"). The danger posed by an impaired surgeon could be the most material information for a patient's choice whether to proceed—greater even than potential physiological complications of the procedure itself.

In short, this appeal asks the Court not to create a new duty or legal claim but instead to apply long-standing informed consent principles and to recognize that any dispute as to the materiality of the risk posed by Dr. Davidson's alcoholism relapse goes to whether he breached his duty to disclose material risks. Like many other disputes over the breach element of a medical malpractice claim, this is a question of fact for the jury.

4. The prospect of professional sanctions or criminal charges is not good grounds for curtailing a physician's duty to disclose material risks to his patient.

The Associations insist South Carolina patients are "already protected" from impaired physicians in such a robust way that it simply is not necessary for a surgeon to disclose his current, uncontrolled alcoholism relapse to his patient. (Associations' Br. at 9-10). Citing an AMA ethics code provision, the South Carolina Board of Medical Examiners' aspirational mission statement, and a criminal statute, the Associations argues a physician is adequately deterred from practicing while impaired. No data is offered in support of this conclusion and the logic is faulty.

The AMA's ethics code is certainly not a foolproof way to root out impaired physicians. The code calls for peer monitoring and reporting, but a sizable percentage of physicians are either unaware of this duty or simply refuse to comply with it.[6] Data like this raises "***important questions about the ability of medicine to self-regulate***."[7] The Associations also note that a physician treating patients while impaired commits a criminal act. (Associations' Br. at 9) (citing S.C. Code Ann. § 40-47-112) but never explain why the existence of a criminal statute obviates the need for a tort remedy. That logic would not make sense in other contexts. The criminal prohibition on murder does not affect the viability of South Carolina's statute authorizing a wrongful death claim for the same act. Nor does the criminal assault statute preclude civil claims for the tort of battery. There is no support and no merit to the Associations' contention that professional and criminal sanctions effectively prevent physicians from practicing while impaired.

5. The Associations' case law analysis is flawed.

Oddly, the Associations then turn from the medicine to offer the Court a strained analysis of informed consent precedents. (Associations' Br. at 6-8). This argument is notable for the opinions the Associations choose to cite and those they choose to ignore.

The Associations rely primarily on two Georgia appellate court rulings (Associations' Br. at 6-7) but fail to acknowledge the very different way in which Georgia law governs informed consent. Georgia regulates a physician's duty to disclose by a statute that specifically identifies the information about a proposed surgery that must be disclosed to the patient. Albany Urology Clinic, P.C. v. Cleveland, 528 S.E.2d 777, 780 (Ga. 2000) (citing Ga. Code Ann. § 31-9-6.1). That

[6] 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 (finding nearly one-third of all physicians surveyed have previously refused to report a suspected impaired or incompetent physician).

[7] Id. at 192 (emphasis added).

statute must be "strict construed" and the required disclosures may not extend beyond the statutory list. Id. Due to this feature of Georgia law, cases from Georgia have little to offer courts in South Carolina or any other state where informed consent is governed by common law.

Moving beyond Georgia, the Associations fail to account for a whole host of opinions from many different states holding that various physician-related dangers must be disclosed to obtain a patient's informed consent. A physician must disclose that he suffers from a potentially communicable disease. Faya v. Almaraz, 620 A.2d 327, 333 (Md. 1993); Behringer v. The Medical Center at Princeton, 592 A.2d 1251 (N.J. Super. 1991). A patient also has a right to know that her physician has an ailment that could cause the physician's hand to shake during the contemplated surgery. Hawk v. Chattanooga Ortho. Group, P.C., 45 S.W.3d 24, 33 (Tenn. App. 2000). Some courts have even held that a physician has a duty to tell a patient if the physician's lack of training or experience on the contemplated procedure could affect the likelihood of a successful outcome. Goldberg v. Boone, 912 A.2d 698, 717 (Md. 2006) (citing Dingle v. Belin, 749 A.2d 157, 165-66 (Md. 2000)); Johnson v. Kokemoor, 545 N.W.2d 495, 505 (Wis. 1996).

The Associations take special aim at Appellants' citation to Hidding v. Williams, 578 So.2d 1192 (La. App. 1991), where similar to this case, the issue was whether a physician's "chronic alcohol abuse" should have been disclosed before spinal surgery. (Associations' Br. at 6 n. 1). The Associations' argument that Hidding has been disavowed or minimized as precedent would be news to the courts that continue to rely on its holdings. Hidding not only remains good law, it has been cited with approval by a state supreme court as recently as 2018 in support of an informed consent claim based on a physician's level of experience and training. Andersen v. Khanna, 913 N.W.2d 526, 539-42 (Iowa 2018); see also DeGennaro v. Tandon, 873 A.2d 191, 196-97 (Conn. App. 2005) (citing Hidding and holding that "if the facts and circumstances of a specific case

indicate that provider specific information would be material to a reasonable patient in deciding whether to embark on a course of therapy, a provider has a duty to disclose that information").

More broadly, the Associations' implication that informed consent is limited to physiological dangers associated with a proposed medical procedure is not consistent with the AMA's own publications. The AMA acknowledges substance abuse certainly harms a physician's ability to provide the medical services and patient communication his job 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"). 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.

Moreover, 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 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.

Finally, 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. Plus, as the AMA acknowledges, 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, the Associations' dalliance into legal analysis fails by relying on distinguishable precedent and overlooking much more relevant case law. The Associations also fail to acknowledge statements made by the AMA where it advocates for the disclosure of physician-related dangers to ensure transparency and to protect the patient's right to self-determination.

CONCLUSION

Based on the arguments stated above, Appellants respectfully request the Court reject the Associations' arguments. Though the Associations claim their view proper balances the relevant interests, they give inadequate consideration to the patient's right to choose. Moreover, the Associations overstate the physicians' privacy interest at play here and offer a flawed view of persuasive authority that is not consistent with the current state of the case law or with the AMA's own statements in other contexts.

Respectfully submitted,

/s/ Jordan C. Calloway
Jay F. Wright
McGowan, Hood & Felder, LLC
135 Edinburgh Court, Suite 202
Greenville, SC 29607
(864) 252-4406
jaywright@mcgowanhood.com

Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
jcalloway@mcgowanhood.com

Attorneys for Appellants

Rock Hill, SC
September 8, 2023