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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM ANDERSON COUNTY
Court of Common Pleas

R. Lawton McIntosh, Circuit Court Judge

Appellate Case No. 2021-001129

Anita and James Chabek, …….. Petitioners,

v.

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

PETITION FOR WRIT OF CERTIORARI

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

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

Attorneys for Petitioners

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CERTIFICATE OF COUNSEL

Pursuant to Rule 242(d)(1), SCACR, Petitioners' counsel hereby certifies that a petition for rehearing was made on December 28, 2023, and denied by the Court of Appeals on February 14, 2024.

QUESTION PRESENTED

1. Whether the material risks a physician must disclose to obtain informed consent are limited to "procedure-specific" risks even when an expert states dangers posed by the physician's medical condition should be disclosed by any reasonable physician.

STATEMENT OF THE CASE

In late summer 2017, Petitioner Anita Chabek began treating with Respondent Larry Davidson, MD at AnMed Health Spine and Neurosurgery (a medical practice operated by Respondent AnMed Health) for lower back pain radiating down her right leg. (R. p. 83). During an August 10, 2017 consultation, Dr. Davidson recommended surgery to resect a right-sided L5/S1 synovial cyst. Id. Dr. Davidson informed Ms. Chabek of some of the risks associated with the surgery including infection, wound healing difficulties, hemorrhage, spinal destabilization, paralysis, nerve injury, and the exacerbation of her current symptoms. Id. Dr. Davidson did not, however, inform Ms. Chabek that he was in the midst of an alcoholism relapse. As it turns out, Dr. Davidson had begun drinking again nearly a year-and-a-half before Ms. Chabek's surgery. (R. p. 88 ¶ 6). By fall 2017, Dr. Davidson was drinking almost daily and could not stop. (R. p. 88 ¶¶ 7, 8).

By December, Dr. Davidson had been arrested for driving under the influence, and he entered inpatient rehabilitation treatment a month later. (R. p. 88 ¶ 11). As the details of Dr. Davidson's alcoholism have come to light, he has provided false or misleading sworn testimony on the matter. (R. p. 78, lines 9-21). Deprived of this crucial information, Ms. Chabek allowed Dr. Davidson to perform her spinal surgery at AnMed Health on August 27, 2017. Had Dr. Davidson disclosed his substance abuse problem, Ms. Chabek would have insisted on a different surgeon. (R. p. 89 ¶ 14). Ms. Chabek also alleged Dr. Davidson made multiple errors during the procedure.

On March 12, 2021, Ms. Chabek and her husband Petitioner James Chabek filed a Notice of Intent to File Suit ("NOI") against Dr. Davidson and AnMed Health (collectively, "Respondents"). The filing included a "Statement of Facts" stating the Chabeks' intent to assert claims against Respondents for medical negligence, lack of informed consent, negligent

supervision, and general negligence. (R. pp. 29- 35 ¶¶ 25-48). Approximately one month later, the Chabeks submitted expert affidavits alleging Dr. Davidson deviated from the standard of care in his performance of Ms. Chabek's surgery. (R. p. 85 ¶ 4). The experts also opined that a reasonable physician in Dr. Davidson's position would have disclosed his substance abuse relapse prior to the surgery. (R. p. 168 ¶¶ 2-3).

Respondents filed motions to dismiss. (R. pp. 98-99). Both motions argued none of Appellants' claims were filed within the time period allowed by the applicable statute of limitations. The Honorable R. Lawton McIntosh heard oral arguments on July 21, 2021. On September 15, 2021, the circuit court entered a Form 4 order granting Respondents summary judgment based on the statute of limitations. A formal order granting summary judgment was entered on November 17, 2021. In that order, the circuit court ruled (1) Ms. Chabek's medical negligence claim was untimely because it accrued at the latest in "early March" 2018; (2) Ms. Chabek's informed consent claim failed as a matter of law because Dr. Davidson had no legal duty to disclose his active alcoholism relapse before performing spinal surgery on Ms. Chabek; and (3) Mr. Chabek's claim for loss of household services was untimely. (R. pp. 16-22). Petitioners filed and served a timely notice of appeal.

The Court of Appeals heard oral arguments on September 14, 2023, and issued its ruling on December 13, 2023. Chabek v. AnMed Health, 442 S.C. 61, 897 S.E.2d 58 (Ct. App. 2023). The Court of Appeals reversed the circuit court's dismissal of Ms. Chabek's medical negligence and negligent supervision claims but affirmed the dismissal of Ms. Chabek's informed consent claim. Specifically, the Court of Appeals ruled South Carolina's informed consent doctrine is "procedure-specific, not physician specific" and does not require a physician to disclosure dangers

associated with a proposed medical procedure if those dangers relate to the physician's "personal life factors." Id. at 78, 897 S.E.2d at 67.

ARGUMENT

1. The application of South Carolina's informed consent doctrine to risks posed by a physician's medical condition is a novel issue.

South Carolina appellate courts' modest informed consent jurisprudence does not include any consideration of whether and how the doctrine applies to risks posed by a physician him or herself. Since the Court of Appeals first recognized the doctrine in Hook v. Rothstein, 281 S.C. 541, 547-48, 316 S.E.2d 690, 694-95 (Ct. App. 1984), this Court appears to have addressed informed consent only three times. Linog v. Yampolsky, 376 S.C. 182, 187-88, 656 S.E.2d 355, 358 (2008) (clarifying that all medical consent-based claims against a physician fall within the medical malpractice framework); Hardee v. Bio-Med. Applications of S.C., Inc., 370 S.C. 511, 516, 636 S.E.2d 629, 631-32 (2006) (referencing importance of disclosing "dangers associated with medical treatment" while recognizing duty owed by physicians to reasonably foreseeable third parties injured by unwarned patients); Harvey v. Strickland, 350 S.C. 303, 566 S.E.2d 529 (2002).[1] Since this Court last spoke on the issue, the Court of Appeals has addressed it only twice more.[2] Nothing in any of these cases directs the result here where a physician's duty to disclose concerns his physical impairment (R. pp. 120-21), and the circuit court's order dismissing the

[1] The Court declined to review the Court of Appeals' ruling in Hook, finding it correctly adopted the "professional medical standard" for evaluating informed consent claims. Hook v. Rothstein, 283 S.C. 64, 320 S.E.2d 35 (1984).

[2] Fletcher v. Med. Univ. of S.C., 390 S.C. 458, 702 S.E.2d 372 (Ct. App. 2010) (finding circuit court erred in directing verdict in favor of physician because patient presented evidence showing she would have declined proposed surgery if warned of risk of arterial and nerve damage); Melton v. Medtronic, Inc., 389 S.C. 641, 698 S.E.2d 886 (Ct. App. 2010) (affirming summary judgment against patient who failed to offer evidence on what risks associated with an intrauterine device a physician must disclose and whether the undisclosed risks would have affected the patient's decision to submit to procedure).

claim was made at a pre-filing stage in the face of an expert affidavit stating any reasonable physician would have made the disclosure. (R. p. 168 ¶¶ 2-3). The circuit court correctly recognized this case presents a novel issue. (R. p. 17).

The Court of Appeals concluded Hook guides the result here. Chabek, 442 S.C. at 66-67, 897 S.E.2d at 78. However, Hook is a forty-year old ruling addressing only a physician's failure to disclose a rare, but fatal, risk of an allergic reaction to contrast material used in diagnostic tests. 281 S.C. at 547, 316 S.E.2d at 694. Hook's holding cannot be grafted in to this case as controlling authority for a factual scenario it did not consider or anticipate and for which the legal and policy considerations vary so significantly. The issue's novelty further supports review because of the split of authority among other jurisdictions to consider it. The Court of Appeals made passing reference to states that reject a duty to disclose dangers the physician's condition poses. Chabek, 442 S.C. at 77, 897 S.E.2d at 66 (citing rulings from Georgia and Pennsylvania). The Court of Appeals also acknowledged these states formed and limit their informed consent doctrine far differently than South Carolina. Id. (noting that, unlike South Carolina, these states strictly limit a physician's disclosure duty by statute or an enumerated list of risks developed in common law).

What the Court of Appeals' ruling overlooks is the substantial number of states allowing informed consent claims under similar circumstances. Louisiana has specifically recognized a surgeon's duty to disclose the risk posed by his severe alcohol abuse. Hidding v. Williams, 578 So.2d 1192, 1196 (La. App. 1991) (finding it "entirely correct" to say a surgeon's alcohol issues were a "material risk" to be disclosed before surgery). Other courts have held a patient should not be asked to consent to a surgery ignorant of the fact that her physician suffers from a debilitating

hand condition[3] or that he suffers from a potentially-communicable disease.[4] Still other courts have interpreted informed consent far more broadly than the Chabeks' claims would require by finding a physician's lack of experience with the procedure and conflict of interests are "material" information that must be disclosed to obtained informed consent.[5]

In sum, the Court should grant the Chabeks' petition to address unresolved questions regarding the vital doctrine of informed consent affecting numerous physician-patient interactions and for which other jurisdictions have issued contradictory rulings.

2. The informed consent "boundaries" adopted by the Court of Appeals conflict with this Court's rulings.

The application of South Carolina's informed consent doctrine to dangers posed by a physician's medical condition is a novel issue, but the limitations the Court of Appeals' ruling imposes on the doctrine conflict with this Court's precedent.

The Court of Appeals recognized South Carolina's view of informed consent has always been "broad and flexible" but reasoned that it is "not without its boundaries." Chabek, 442 S.C. at 78, 897 S.E.2d at 67. The boundaries chosen stand at odds with precedent. First, the Court of Appeals reasoned that, since a physician's duty to disclose relates to "material risks involved in the procedure," South Carolina's informed consent doctrine is "procedure-specific." Id. (citing

[3] Hawk v. Chattanooga Ortho. Group, P.C., 45 S.W.3d 24, 33 (Tenn. App. 2000) (finding disclosure of this ailment was included in the surgeon's duty to "supply appropriate information" to enable patient to provide informed consent).

[4] 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) (hospital's duty regarding HIV positive surgeon).

[5] Andersen v. Khanna, 913 N.W.2d 526 (Iowa 2018); 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); Moore v. Regents of Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990) ("a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment" and failure to do so "may give rise to a cause of action for performing medical procedures without informed consent").

Hook v. Rothstein, 281 S.C. at 547, 316 S.E.2d at 694-95). Second, the Court of Appeals appeared to use the same Hook language to conclude "the risk must be involved in the procedure *itself*." Chabek, 442 S.C. at 78, 897 S.E.2d at 67 (emphasis in original). The Court of Appeals then reasoned no "personal life factor" of the physician performing the procedure could fall within the disclosure duty because those factors are not "inherent to the procedure." Id. Limiting the informed consent doctrine to "procedure-specific" risks is not consistent with this Court's precedent. Nearly 20 years after Hook, this Court recognized a viable informed consent claim for an undisclosed risk that was neither specific to nor inherent in a patient's brain surgery. Harvey, 350 S.C. at 309-11, 566 S.E.2d at 532-34.

The patient in Harvey underwent a carotid endarterectomy at Lexington Medical Center as well as additional surgical interventions when complications arose from the original procedure. Id. at 306-07, 566 S.E.2d at 531. The dispute centered on communications between physician and patient regarding the patient's religion-based aversion to the use of blood products during any medical procedure. Id. While the physician did not transfuse his patient with blood during the endarterectomy, two units of packed red blood cells were used in the follow-up procedure. Id. at 307, 566 S.E.2d at 532. Following the patient's recovery, the physician faced an informed consent-based claim related to risks created by the patient's personal aversion to blood transfusions. At trial, the circuit court directed a verdict to the physician on this claim, but this Court reversed. Id. at 312-13, 566 S.E.2d at 534. In other words, Harvey found a viable informed consent claim related to a risk of exsanguination (i.e. severe blood loss) that arose not from the procedure itself, but from the patient's conscience-based religious preference. Thus, procedure-specificity and the degree to which a risk "inheres" to the procedure are not appropriate boundaries on South Carolina's informed consent doctrine.

The boundaries the Court of Appeals chose also fail to account for other important language from precedent. Procedure-specificity and inherence boundaries were adopted despite the Court of Appeals acknowledging a physician's duty to disclose extends broadly to "the dangers associated with medical treatment" including all "attendant risks and effects." Chabek, 442 S.C. at 76, 897 S.E.2d at 66 (quoting Hardee, 370 S.C. at 516, 636 S.E.2d at 631-32). Hardee's decision to extend the disclosure duty to "attendant risks and effects" is inconsistent with the Court's procedure-specificity boundary. A New Jersey court interpreted similar language in Behringer v. Med. Ctr. at Princeton, 592 A.2d 1251 (N.J. Super. 1991). New Jersey common law extended a physician's duty to disclose to both "the nature of the treatment" and "any attendant substantial risks." Behringer held this language was broad enough to require a surgeon to tell potential patients that he was HIV-positive before operating on them. Id. at 1255. In fact, this language was the specific reason why the court rejected the surgeon's argument that his physical ailment was beyond the reach of an informed consent claim. Id. at 1281 (noting argument that duty to disclose did not include "surgeon's physical condition" but citing "attendant substantial risk" language to find "informed consent cases are not so narrow").

Therefore, the Court of Appeals' opinion merits review because it adopted limitations on the scope of an informed consent claim that conflict with this Court's ruling in Harvey and the principles it recognized in Hardee.

3. Limiting a physician's disclosure duty to "procedure-specific" dangers oversteps the judicial role, undermines patient autonomy, and conflicts with professional standards.

Finally, the Court should grant the Chabeks' petition to consider the negative policy implications of the Court of Appeals' ruling. For one, the ruling is an anomaly in its approach to resolving disputes over the scope of a medical provider's duty. When Hook announced a

physician's duty to disclose "material" risks, the Court of Appeals recognized the scope of that duty would have to be determined within the parameters of any particular case. The disclosure duty would cover "material" risks, with materiality meaning those risks "a reasonable medical practitioner" would make under the circumstances as established by "expert medical evidence." Hook, 281 S.C. at 553, 316 S.E.2d at 698. Scope and breach questions in malpractice cases have always been considered matters of medical complexity for the parties' experts to debate, not for courts to dictate. Dawkins v. Union Hosp. Dist., 408 S.C. 171, 176-77, 758 S.E.2d 501, 504 (2014) (finding that the resolution of breach questions in malpractice cases generally require "medical knowledge"); Stallings v. Ratliff, 292 S.C. 349, 353, 356 S.E.2d 414, 417 (Ct. App. 1987) (noting need for experts "in deciding the issue of breach of duty, because it involves questions of medical knowledge and judgment not within the comprehension or experience of layman"). Informed consent claims are a subset of medical malpractice and are subject to this same rule.

> [T]he scope of a physician's duty to disclose is measured by those communications a reasonable medical practitioner in the same branch of medicine would make under the same or similar circumstances. Because disclosure is an integral part of the physician's diagnosis and treatment of his patient and because **the reasonableness of a disclosure often involves questions of medical knowledge and judgment**, we determined the plaintiff in a malpractice action against a physician must ordinarily establish a breach of the duty to disclose by expert testimony.

Botehlo v. Bycura, 282 S.C. 578, 588, 320 S.E.2d 59, 65 (Ct. App. 1984) (citing Hook) (emphasis added).

Here, the Court of Appeals stepped outside of the proper judicial rule to rule as a matter of law that the scope of a physician's disclosure duty does not extend to dangers posed by the physician's medical condition. Chabek, 442 S.C. at 78, 897 S.E.2d at 67 (holding that "the informed consent doctrine does not require a physician to disclose personal life factors"). The Court of Appeals even reached this conclusion in the face of an expert orthopedic surgeon's

affidavit stating Dr. Davidson's failure to disclose his physical condition was unreasonable (R. p. 168 ¶ 3) and inconsistent with what a reasonable surgeon would do under the circumstances. (R. p. 168 ¶ 2). In so ruling, the Court of Appeals goes to a place South Carolina's appellate courts have never been before. While a court may be required to grant judgment as a matter of law in a physician's favor if the plaintiff fails to provide expert testimony on breach, there does not appear any precedent for a court disregarding an expert to decide on its own the medical parameters of a physician's duty. A court would never rule a physician's disputed surgical technique or medication dosage choice was not unreasonable as a matter of law because the reasonableness of those decisions turns on medical knowledge rather than legal principles. Medical malpractice law has always relied on experts to determine what is reasonable. The Court of Appeals strayed from that established principle by drastically curtailing what a reasonable physician must disclose to his patient.

The error was not just in choosing to step into a role for which courts have always deferred to medical experts, it was also the specific choice the Court of Appeals made in that role. There are a number of concerning implications of adopting "procedure-specificity" as a boundary for the informed consent doctrine. For one, that proposed boundary is itself ill-defined. By finding a physician's "personal life factors" never fall within the disclosure duty, the Court of Appeals seems to define "procedure-specific" to mean physiological complications of the proposed medical treatment in the abstract. Still, the holding could be construed as narrower than how the Court of Appeals chose to frame the issue. The issue was described as whether a physician must disclose "personal, medical, and behavioral issues" while the holding was stated in terms of "personal life factors." Chabek, 442 S.C. at 76, 78, 897 S.E.2d at 66, 67. This disparity could certainly create

ambiguity for future cases where the risk in question arises from different types of hardships ranging from a surgeon's deteriorating eyesight to depression.[6]

If "procedure-specific" is intended to limit the disclosure duty to physiological complications of the proposed medical treatment in the abstract, that too has substantial implications. After all, if "procedure-specific" excludes all things "physician-specific" (Id. at 78, 897 S.E.2d at 67), it would also seem to exclude all things "patient-specific." That would mean none of the risk factors posed by the patient's unique health profile could ever form the basis for an informed consent claim. For example, if the risk of a serious cardiac complication from a routine surgery was generally low but greatly elevated by a patient's obesity or smoking habit, the "procedure-specific" rule means a surgeon is legally free to leave his patient in the dark on just how risky her seemingly routine procedure actually is. Even if that patient bucks the odds and comes through surgery unscathed, the fact that she was forced to unknowingly face such a risk is a betrayal of the professional and legal relationship she formed with her physician.

Similarly, the "procedure-specific" rule undermines patient autonomy, the core policy underpinning the informed consent doctrine. Hook recognized the doctrine is grounded in "the patient's right to exercise control over his or her own body by deciding for himself or herself whether or not to submit to the particular procedure." 281 S.C. at 547-48, 316 S.E.2d at 695 (citing Sard v. Hardy, 379 A.2d 1014, 1019 (Md. 1977)). 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

[6] The Court of Appeals' "inherence" boundary is no different. Determining what is "inherent" to surgery is not as simple as one might suspect. Hook is not clear in what sense the term is deployed. This Court seemed to take the term from a jury charge the circuit court issued at trial. Hook, 281 S.C. at 562 n. 5, 316 S.E.2d at 703 n. 5. The source of that charge is unclear. It is also far from clear that "inherent" has any substantive meaning beyond "material." Id. (charging jurors that a physician has a duty to disclose "dangers inherent in the treatment" but later charging jurors the duty extends to "risks which are material to the proposed procedure").

S.E.2d at 533 (2002) (quoting Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891)) ("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)). To maintain her autonomy among the inevitable uncertainty of the medical world, a patient should be informed of serious risks associated with proposed medical procedures whether the danger is specific to the procedure or to the professional performing it.

Finally, the Court should consider just how far the "procedure-specific" rule deviates from what the medical profession expects from its practitioners. From its inception in this state, the informed consent doctrine has always been defined by a "professional standard," meaning the scope of duty is defined by what a physician would be expected to disclose rather than what a patient may expect to be told. Hook, 281 S.C. at 548-53, 316 S.E.2d at 695-98. The medical profession's view on reasonable disclosures to obtain informed consent does not align with a "procedure-specific" rule. Several provisions within the American Medical Association's ("AMA") Code of Medical Ethics require a physician to disclose non-"procedure-specific" risks to obtain a patient's consent and to make that patient's consent truly "informed."

The AMA Code of Medical Ethics states that a patient is always "entitled to choose [her] own physicians." (App'ts. Resp. to Amicus Curiae Br. of S.C. Hosp. Ass'n at 5) (citing 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." (App'ts. Resp. to Amicus Curiae Br. of S.C. Hosp. Ass'n at 6) (citing 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. (App'ts. Resp. to Amicus Curiae Br. of S.C. Hosp. Ass'n at 6) (citing 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." (App'ts. Resp. to Amicus Curiae Br. of S.C. Hosp. Ass'n at 6) (citing Am. Med. Ass'n Code of Medical Ethics § 11.2.4).

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." (App'ts. Resp. to Amicus Curiae Br. of S.C. Hosp. Ass'n at 6-7) (citing Am. Med. Ass'n Code of Medical Ethics § 8.6, "Promoting Patient Safety" (2016)). Any legal rule that would encourage physicians to conceal important information from their patients is both an ethics and safety issue. (App'ts. Resp. to Amicus Curiae Br. of S.C. Hosp. Ass'n at 7) (citing 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, a review of the Court of Appeals' ruling should be granted not only because of the novel issue and conflicts with this Court's precedent, but also because of serious policy concerns regarding how the ruling was reached, how it would be applied going forward, and how it comports with both medical professional standards and the important policy of patient autonomy that informed consent is supposed to serve.

CONCLUSION

For all these reasons, the Chabeks respectfully requests the Court grant their petition for writ of certiorari and reverse the Court of Appeals' ruling.

Respectfully submitted,

/s/ Jordan C. Calloway

Jay F. Wright (SC Bar No. 78738)
McGowan, Hood, Felder & Phillips, LLC
135 Edinburgh Court, Suite 202
Greenville, SC 29607
(864) 252-4406
jaywright@mcgowanhood.com

Jordan C. Calloway (SC Bar. No. 78728)
McGowan, Hood, Felder & Phillips, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
jcalloway@mcgowanhood.com

Attorneys for Petitioners

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Rock Hill, SC