THE STATE OF SOUTH CAROLINA
In the Supreme Court

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S.C. SUPREME COURT

APPEAL FROM ANDERSON COUNTY
Court of Common Pleas

R. Lawton McIntosh, Circuit Court Judge

Supreme Court Case No. 2024-000413

Anita and James Chabek, …….. Petitioners,

v.

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

REPLY IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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REPLY ARGUMENT

1. The Chabeks' question presented is novel and squarely presented by the record in this case.

Respondents AnMed Health and Larry Davidson, MD first argue the Court need not address the question the Chabeks' petition poses because existing South Carolina precedent has already effectively decided the matter. (Return at 9). Respondents do not cite any South Carolina authority addressing an informed consent claim arising from dangers posed to a patient by a physician's medical condition. In fact, it does not appear this Court has substantively addressed informed consent at all in over 15 years. (Pet. at 5) (discussing limited South Carolina precedent on informed consent doctrine). Respondents' argument that the issue here is not new seems to be half-hearted as they have previously acknowledged its novelty. (Resp'ts. Br. at 30) ("there is no appellate opinion in South Carolina addressing whether a physician is required to disclose personal issues . . .").

Respondents offer one South Carolina Court of Appeals opinion to suggest the issue here has already been decided. (Return at 8-10) (citing Hook v. Rothstein, 281 S.C. 541, 316 S.E.2d 690 (Ct. App. 1984)). But, Hook cannot be seen as decisive or even strong guidance here because it considered only a physician's duty to disclose the risk of allergic reaction posed by contrast material used during diagnostic procedures. Id. at 546-47, 316 S.E.2d at 694. Hook's choice to adopt the "professional standard" to measure a disclosure duty does not mean that duty cannot extend to dangers a physician poses. All the professional standard does is view the disclosure duty through the lens of a reasonable physician, requiring the disclosure of all dangers a reasonable physician would explain to the patient under the same or similar circumstances. Id. at 548, 316 S.E.2d at 695. An expert's opinion is the most common way to show a physician met or violated this standard. Id. at 548-49, 316 S.E.2d at 695. Nothing in that standard or Hook's discussion of it

suggests physicians, as a matter of law, must only disclose "procedure-specific" dangers as the Court of Appeals held.

Instead, Hook deliberately chose to leave the scope of a physician's duty to be defined by expert testimony. Even at the pre-filing Notice of Intent to File Suit ("NOI") stage, the Chabeks presented an expert opinion to show Davidson breached his disclosure duty prior to Ms. Chabek's back surgery. (R. p. 168). Orthopedic surgeon Sanford H. Davne's affidavit states that disclosure of Davidson's active alcoholism relapse was "part of [a] proper informed consent" discussion (R. p. 168 ¶ 3) and "what a reasonably prudent neurosurgeon would do." (R. p. 168 ¶ 2). Accordingly, this case concerns an important legal question no South Carolina appellate court has ever considered, and that question is squarely presented here as the Chabeks supported their NOI with an expert opinion sufficient to show Davidson violated the professional standard for informed consent.

2. Respondents present a misleading picture of persuasive authority.

While South Carolina's appellate courts have not addressed whether the informed consent doctrine encompasses physician-related dangers, a number of other jurisdictions have. Respondents' summary of some such opinions (Return at 10-15) shows the deep divide among these rulings and the vastly different approaches courts have taken to address the issue. This split of authority is itself a factor supporting this Court's review. Spahn v. Town of Port Royal, 330 S.C. 168, 170, 499 S.E.2d 205, 206 (1998) (citing split in persuasive authority regarding "last clear chance" doctrine as grounds for granting certiorari). For an issue this consequential and where so many jurisdictions have reached conflicting results, it ought to be this Court that charts South Carolina's course in shaping the state's common law-based informed consent doctrine.

In substance, Respondents' discussion of these cases is flawed in multiple ways. Respondents draw a false parallel between this case and opinions from other states interpreting a physician's disclosure duty narrowly. (Return at 10-12). For example, they rely heavily on a Georgia Supreme Court case even though Georgia's view on informed consent has a different origin and a narrower scope than what has previously been discussed by South Carolina courts. (Return at 10-11) (citing Albany Urology Clinic, P.C. v. Cleveland, 528 S.E.2d 777 (Ga. 2000)). Georgia law governs informed consent by a very narrow statute. Id. at 779-80 (citing Ga. Code Ann. § 31-9-6.1). Since the state chooses to regulate physician disclosures by statute, Georgia "does not impose a general requirement of disclosure upon physicians." Id. at 780. Instead, the disclosure duty is limited to a statutory list that courts cannot not expand and must "strictly construe[]." Id. Unlike South Carolina's common-law based informed consent rule requiring disclosure of all "material risks," the Georgia statute only requires a physician to discuss the risk of "infection, allergic reaction, disfigurement, brain or heart damages, etc." Id. at 779 n. 9 (citing Ga. Code Ann. § 31-9-6.1(a)(1)-(6)). Thus, Albany Urology was constrained by Georgia's narrowly-written statute, but South Carolina courts are not.[1]

Respondents also use these cases to argue the Court of Appeals restricting a physician's disclosure duty to "procedure-specific" dangers was wisely selected as a limiting principle to prevent South Carolina's informed consent doctrine from becoming unwieldy. (Return at 12-13).

[1] Respondents' reliance on Pennsylvania cases is flawed for similar reasons. (Return at 11-12) (citing Duttry v. Patterson, 771 A.2d 1255 (Pa. 2001); Kaskie v. Wright, 589 A.2d 213 (Pa. Super. 1991)). As the Court of Appeals acknowledged, that state's informed consent doctrine has been limited to a "specific list of disclosures." Chabek v. AnMed Health, 442 S.C. 61, 77, 897 S.E.2d 58, 66 (Ct. App. 2023). South Carolina courts have (1) never established a list of required disclosures; (2) never suggested our version of the disclosure duty can be reduced to a list; and (3) never hinted that the courts would be the appropriate authority to author any such list should having one be deemed proper.

However, the Court of Appeals' approach is a substantial departure from South Carolina's long-standing rules for addressing medical issues. The Court of Appeals effectively ruled, 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. In one fell swoop, the Court of Appeals plucked from the universe of material risks all potential dangers except the potential physiological complications of a proposed medical procedure.

By doing so, the Court of Appeals puts the courts in the uncomfortable position of stepping out of their 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 NOI stage of a medical malpractice suit, disregard an unopposed expert affidavit, and rule on the materiality of dangers posed by a surgeon's impairment. 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 reverse course on the Court of Appeals' dangerous precedent and resolve this appeal 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 v. Bio-Medical Applications of S.C., Inc., 370 S.C. 511, 516, 636 S.E.2d 629, 631-32 (2006). Even at the NOI 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 stands as 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 they have no remedy for him taking away their right to make an informed choice about a serious medical procedure.

Respondents also err in summarily dismissing substantial persuasive authority finding informed consent can encompass a duty to disclose physician-related dangers. (Return at 13-15). Respondents argue the most factually similar case and several others hold no persuasive value unless they arise in a jurisdiction applying the professional standard. Id. at 13-14 (citing Hidding v. Williams, 578 So.2d 1192 (La. App. 1991)).[2] What Respondents never explain is why South

[2] Respondents' contention that Hidding has been disavowed or minimized as precedent (Return at 14 n. 4) 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

Carolina's adoption of the professional standard prevents these similar factual cases from offering persuasive value here. The Chabeks are not arguing Davidson violated South Carolina's informed consent rules because *they feel* Ms. Chabek should have been informed about Davidson's active alcoholism relapse. Instead, they argue Davidson had a duty to disclose this danger because *their expert says* any reasonable surgeon would have done so. (R. p. 168 ¶¶ 2-3). The Chabeks' NOI and its attachments meet the professional standard, and there is no reason for this Court to ignore the several others that have held physician-related dangers can be the subject of an informed consent claim.

Respondents also ask the Court to ignore precedent from at least three other states finding a physician had a duty to disclose serious dangers posed by his/her health condition. There is no need for the Court to consider a Tennessee ruling holding that a surgeon must disclose his disabling hand condition prior to surgery, Respondents argue, because the Chabeks do not allege a link between Davidson's alcoholism relapse and Ms. Chabek's surgery. (Return at 14-15) (citing Hawk v. Chattanooga Orthopaedic Group, P.C., 45 S.W.3d 24, 33-34 (Tenn. Ct. App. 2000)). That is simply not true. The Chabeks allege Davidson's relapse began over a year before Ms. Chabek's surgery, and he drank more frequently in the months before her procedure. (R. p. 88 ¶¶ 6-7). It is Davidson's months-long, uncontrolled alcohol addiction that posed dangers Ms. Chabek was entitled to know and that any reasonable surgeon would have disclosed.

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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").

In sum, the substantial split in authority among other jurisdictions is further support for the Chabek's request for further review of the Court of Appeals' ruling. Respondents' discussion of the persuasive authority does not prove otherwise as they fail to acknowledge the very different ways in which Georgia and Pennsylvania think about informed consent and fail to credit the many different states that have found a duty to disclose under circumstances very similar to those presented here.

3. The Court of Appeals' opinion cannot be reconciled with this Court's ruling in Harvey.

The Court of Appeals ruling South Carolina's informed consent doctrine is "procedure-specific," is inconsistent with how this Court applied the doctrine in Harvey v. Strickland, 350 S.C. 303, 566 S.E.2d 529 (2002). Harvey, reversing a directed verdict to the physician, found a patient had a viable informed consent claim against the physician for giving the patient a blood transfusion. Id. at 306, 566 S.E.2d at 531. The physician breached his duty to obtain informed consent because the patient's religious beliefs prevented him from accepting transfusions. Id. at 307-08, 566 S.E.2d at 532. The danger was not that the patient may develop a blood clot from the transfusion or that he could develop a hemolytic transfusion reaction if the transfused units did not match his blood type. Instead, the danger was that the patient would suffer a religious and dignity injury because of his personal religious conviction. Thus, the informed consent claim recognized in Harvey was not in any way procedure-specific.

Respondents argue Harvey is distinguishable because it involved a patient who received "unwanted medical treatment." (Return at 16). However, that is not a distinction at all. Ms. Chabek also received unwanted medical treatment. She had no desire to undergo intricate spinal surgery at the hands of a physician in the midst of an uncontrolled alcoholism relapse. (R. p. 89 ¶ 14). In fact, if this information had been provided to her, she would have made clear to Davidson just how

unwanted the proposed medical treatment really was. Id. Moreover, even if this was a distinction, it is not one that makes a difference. The key takeaway from Harvey is that an informed consent claim can be maintained even if the danger in question was not a physiological complication from the anticipated procedure itself. That is the principle from Harvey demonstrating the error in the Court of Appeals' "procedure-specificity" rule, and the Court of Appeals' departure from the Harvey precedent is a key reason this Court should grant the Chabeks' petition.

4. Respondents' policy arguments undermine the patient protections the informed consent is designed to provide.

Respondents close with four policy arguments for why courts should step in to state narrow and stiff restrictions on a physician's disclosure duty. Their first argument is also the most perplexing. Respondents contend that excluding physician-related dangers from the disclosure duty is consistent with the purpose of informed consent. (Return at 18-19). However, the purpose of informed consent is patient autonomy. Hook grounded the doctrine 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)). 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.

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 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. Those interests are served with providing the patient more information rather than less, and Respondents offer no explanation for how patient autonomy is enhanced by encouraging physicians to withhold crucial information about themselves from their patients.

Second, Respondents conclude any requirement for disclosure of any physician-related danger would lead to confusion and endless litigation. (Return at 19). Respondents point to nothing to support this conclusion. There is no evidence of a litigation explosion in those states that have expressly recognized the disclosure duty encompasses at least some physician-related dangers. Respondents' gloomy forecast is also not borne out in South Carolina for other forms of medical malpractice. Whether the suit stems from an alleged medication error or a failure to obtain informed consent, the duty is the same—a physician must do what a reasonable practitioner would have done under the same or similar circumstances. From there, courts leave the matter of breach for experts to debate and jurors to resolve. Thus, despite Respondents' protestations, an informed consent claim based on a physician-related danger is no more boundless or uncertain than any other form of medical malpractice claim.

A South Carolina appellate court would never step in and declare, as a matter of law, that prescribing a certain dosage of a disputed medication is or is not malpractice. But, that is essentially what Respondents are pursuing here in the informed consent context. They are asking the courts to decide that a reasonable physician would not disclose to his surgical patient any danger arising from the physician's personal, physical condition. The Court of Appeals erred in doing so, and it is important that this Court grant the Chabeks' petition to address the matter.

Third, Respondents insist that recognizing physician-related dangers could be part of the disclosure duty is something the medical industry would not abide and does not need because of its robust system for self-regulation. (Return at 20-22). For example, Respondents argue American Medical Association ("AMA") ethical standards do not "require or recommend that a physician disclose persona life factors." (Return at 20). That is simply false. A physician's financial stake in a drug he prescribes or a medical device he recommends certainly counts as a "personal life factor," and the AMA calls for a physician to disclose this to his/her patient before writing the prescription. Am. Med. Ass'n Code of Medical Ethics § 11.2.4, "Transparency in Health Care" (2016) (referring to a physician's "financial incentives").

This provision is not surprising because, in many ways, the AMA ethics code is like South Carolina's informed consent doctrine in its focus on patient autonomy. Am. Med. Ass'n Code of Medical Ethics § 11.2.4 ("Respect for patients' autonomy is a cornerstone of medical ethics"). The AMA code stands strongly against efforts to restrict the information a physician tells his/her patient because those efforts undermine the physician-patient relationship. 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").

Respondents' argument that the medical industry effectively self-regulates against physician-related dangers is equally dubious. 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.[3] 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."[4] 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.[5] These startling statistics led researchers behind the survey to conclude there are "***important questions about the ability of medicine to self-regulate***."[6]

Finally, Respondents argue there is no reason for an informed consent claim here because Ms. Chabek also asserted a medical malpractice claim for surgical errors Davidson committed during her back surgery. (Return at 20-21). But, that argument again ignores Harvey. Harvey reversed directed verdicts that had been granted on both informed consent and medical malpractice claims. The former was based on a violation of the patient's religion-based choice to refuse blood transfusions. The latter was based on expert testimony stating that the patient's medical condition was not sufficient severe to warrant a transfusion. There is no merit to Respondents' suggestion

[3] Katherine Harmon, "Many physicians fail to report incompetent or incapacitated colleagues," *Scientific American*, July 13, 2010.
[4] 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.
[5] Id. at 192.
[6] Id. (emphasis added).

that an aggrieved patient may recover on only one or the other of these causes of action. Even if recovery on one of these claims could preclude recovery on the other, Ms. Chabek would not be required to choose between the two at the NOI stage of this litigation. Rule 8(a), SCRCP ("Relief in the alternative or of several different types may be demanded").

CONCLUSION

For all these reasons and those referenced in their earlier filing, the Chabeks respectfully request the Court grant the petition for writ of certiorari. The Court of Appeals substantially limited the scope of South Carolina's informed consent law by imposing a "procedure-specificity" requirement for a physician's disclosure duty. Since this is a novel issue, the Court of Appeals could not have relied on South Carolina precedent to reach that conclusion, and its ruling stands at odds with this Court's previous applications of the informed consent doctrine. That ruling also undermines the patient autonomy interest informed consent is designed to protection and creates real world problems for the trust that must form the basis for the physician-patient relationship. Physicians, patients, and attorneys would all be well served by this Court addressing these novel legal and important policy questions.

Respectfully submitted,

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