WILLIAMS V. QUEST: THE SOUTH CAROLINA SUPREME COURT’S MISDIAGNOSIS OF QUEST DIAGNOSTICS AS A HEALTH CARE PROVIDER AND THE POOR PROGNOSIS FOR PLAINTIFFS IN MEDICAL MALPRACTICE

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INTRODUCTION

On June 27, 2018, the South Carolina Supreme Court answered a certified question concerning Williams v. Quest Diagnostics, Inc. (“Williams v. Quest”) from the South Carolina District Court.1 This wrongful death lawsuit was filed against Quest Diagnostics, Inc. (“Quest”) by Amy Williams (“Williams”) nearly ten years after the death of her infant son2 following a traumatic seizure.3 The nucleus of Williams’ claim derived from a mislabeled Deoxyribonucleic acid (“DNA”) test performed by Athena Diagnostics4 (“Athena”) in an effort to diagnose her son’s recurring seizures.5 The District Court Judge certified the following question to the South Carolina Supreme Court (“the Court”):

“Is a federally licensed genetic testing laboratory acting as a ‘licensed health care provider’ as defined by S.C. Code Ann. § 38-79-410 when, at the request of a patient’s treating physician, the laboratory performs genetic testing to detect an existing disease or disorder?”6

The Court’s decision, written by Justice Kittredge, answered in the affirmative.7 Based on this decision, South Carolina law now recognizes third party genetic testing laboratories (“diagnostic labs”) as within the same category as hospitals when a treating physician orders a diagnostic test.8 As a result, diagnostic labs will be able to reap the benefits of the defendant-friendly procedures and outcomes of medical malpractice claims in South Carolina. The consequence of Williams v. Quest will

2. Out of respect for Amy Williams, a loving and spirited mother, her late son’s name will be omitted from this Note.
3. Williams, 816 S.E.2d at 564.
6. Williams, 816 S.E.2d at 564.
7. Id.
8. Id.
further insulate corporate defendants from lawsuits and intensify the grueling battle for plaintiffs in medical malpractice lawsuits in South Carolina. This Note argues that the South Carolina Supreme Court misinterpreted section 38-79-410 to include diagnostic labs as health care providers and, therefore, the opinion should be subsequently overruled.

Section II of this Note discusses the underlying claim in Williams v. Quest and the circumstances leading up to the claim. Section III analyzes the Court’s questionable holding and interpretation of S.C. Code Ann. § 38-79-410, highlights the dissimilarities between diagnostic laboratories and hospitals, and assesses a former certified question concerning the same statute answered by the Court in Swanigan. Section IV reviews medical malpractice law in South Carolina and the difficulty faced by plaintiffs in medical malpractice lawsuits. Finally, Section V focuses on the unentitled relief granted to third party diagnostic labs like Quest, a multi-billion dollar corporation, in medical malpractice actions, and concludes that the Court’s opinion is unsound and should be overruled.

SECTION II. WILLIAMS V. QUEST: DNA VARIANT OF KNOWN OR UNKNOWN SIGNIFICANCE?

Amy Williams’ son was born on August 23, 2005. He was only four months old when he began suffering from febrile focal motor seizures. The severity and frequency of the seizures

9. See infra Section II.
10. See infra Section III.
11. See infra Section IV.
12. See infra Section V.
14. Id.; See also “Febrile seizures are events brought on by a fever in infants or small children during which a child may lose consciousness and shake, moving limbs on one or both sides of the body. Focal or partial seizures occur when abnormal electrical activity causing the seizure starts and remains in one part of the brain.” Ruth C. Shinnar and Shlomo Shinnar, Febrile Seizures, Child Neurology Foundation, http://www.childneurologyfoundation.org/disorders/febrile-seizures/ (last visited Nov. 6, 2018).
increased in the months to follow.\textsuperscript{15} The treating neurologist prescribed “sodium channel blocking medications” that are routinely utilized to treat varying types of seizures.\textsuperscript{16} Unfortunately, the use of these medications was unsuccessful.\textsuperscript{17} On January 18, 2007, in an effort to properly diagnose her son’s condition, his doctors ordered a whole blood sample to be taken for testing.\textsuperscript{18} DNA was extracted from the blood sample and delivered to Athena’s laboratory for an Sodium Channel, Voltage-Gated, Type 1 Alpha Subunit (“SCN1A”) DNA Sequencing Clinical Diagnostic Test.\textsuperscript{19}

On June 30, 2007, the SCN1A DNA Sequencing Clinical Diagnostic Report (“the 2007 Report”) indicated that Williams’ son had a DNA sequence variant in the SCN1A gene and catalogued the mutation as a “#4: Variant of unknown significance.”\textsuperscript{20} Specifically, the 2007 Report classified the DNA sequence variant as (“1237T>A, Y413N”). The 2007 Report stated that the “DNA sequence variants. . .have not been correlated with clinical presentation and/or pathology in the current literature.”\textsuperscript{21} In other words, Athena determined that there was insufficient evidence at the time of the 2007 Report to effectively classify (“1237T>A, Y413N") as a disease causing alteration.\textsuperscript{22}

Williams first contended that the 2007 Report was intrinsically wrong because the variant by definition should have been labeled as “#3: Amino acid change of unknown significance.”\textsuperscript{23} Williams also argued that there was sufficient literature regarding (“1237T>A, Y413N") in 2007 and the Chief CLIA Laboratory Director for Athena, Batish, knew or should have known that the classification was wrong.\textsuperscript{24}

\begin{itemize}
  \item \textsuperscript{15} Am. Compl. ¶ 12.
  \item \textsuperscript{16} Id. ¶ 13.
  \item \textsuperscript{17} Id.
  \item \textsuperscript{18} Id. ¶ 14.
  \item \textsuperscript{19} The test is used in “diagnosing or detecting an existing disease, illness, impairment, symptom or disorder.” Id. ¶ 15.
  \item \textsuperscript{20} Id. ¶ 17.
  \item \textsuperscript{21} Williams, 353 F. Supp. 3d at 436.
  \item \textsuperscript{22} Id.
  \item \textsuperscript{23} Am. Compl. ¶ 20.
  \item \textsuperscript{24} Id. ¶ 24.
\end{itemize}
At the time of the 2007 Report, there were two publications, “Berkovic et al., 2006 & Harkin et al., 2007,” known to Athena that associated her son’s specific DNA mutation with Dravet Syndrome, a severe form of epilepsy. Since both publications were available to Athena, Williams claimed that the variance would qualify as “#1: Known disease-associated mutation.”

Next, the 2007 Report shows that Batish reviewed and submitted the test results. Astonishingly, Batish was one of the authors of the “Harkin et al., 2007” publication that found (“1237T>A, Y413N”) is linked to Dravet Syndrome. Even with this knowledge, Batish failed to discover the error in the 2007 Report. Athena’s failure to properly identify the DNA mutation triggered months of erroneous treatment that was not appropriate for Dravet Syndrome. In fact, the treatment provided to her son exacerbated his seizures. As a result, Amy Williams’ son passed away on January 5, 2008.

Williams decided to bring the suit against Quest after she received a copy of the 2007 Report in September 2014. She had never seen the 2007 Report prior to her request. In January 2015, Quest and Athena produced a Revised Report (“the 2015 Report”) which accurately classified her son’s DNA mutation as a “known disease associated mutation” consistent with Dravet Syndrome. The 2015 Report did not cite “new publication references” and was supposedly authorized by the same physicians from the 2007 Report, even though the physicians left the employment of Athena in 2009. After the suit was filed in the Court of Common Pleas for Richland County, South Carolina, Williams’ action was removed to District Court on March 28.

25. Id. ¶ 21-22.
26. Id.
27. Id. ¶ 24.
28. Id.
31. Id. at 437.
32. Id.
33. Williams, 353 F. Supp. 3d at 436.
34. Id.
35. Id.
2016.\textsuperscript{37} Thereafter, Quest filed a motion to dismiss maintaining that the amended complaint is barred by the six-year statute of repose applicable to actions brought against licensed health care providers, and that Quest qualifies as a “licensed health care provider,” as described by S.C. Code Ann. § 38-79-410.\textsuperscript{38} The District Court then certified the question to the South Carolina Supreme Court:

“Is a federally licensed genetic testing laboratory acting as a ‘licensed health care provider’ as defined by S.C. Code Ann. § 38-79-410 when, at the request of a patient’s treating physician, the laboratory performs genetic testing to detect an existing disease or disorder?”\textsuperscript{39}

SECTION III. THE SOUTH CAROLINA SUPREME COURT WENT BEYOND THE INTENT OF THE LEGISLATURE AND CREATED A NEW DEFINITION OF HOSPITAL TO EMBRACE QUEST

The South Carolina Supreme Court ruled in a 4-1 decision that Quest Diagnostics, Inc. is classified as a health care provider as contemplated by S.C. Code Ann. § 38-79-410.\textsuperscript{40} The Court found the answer primarily by comparing diagnostic labs to hospitals as defined in South Carolina law.\textsuperscript{41} Once Quest was categorized as a hospital, the Court held that it “clearly” fits within section 38-79-410.\textsuperscript{42} The following subsections assess the Court’s reasoning in Williams v. Quest, highlight the distinctions between hospitals and diagnostic labs, and apply the Court’s interpretation in Swanigan to diagnostic labs.

A. The Court Neglected Precedent and Employ Erroneous Methodology

Justice Kittredge wrote the opinion of the Court which

\textsuperscript{37} Williams, 353 F. Supp. 3d at 436.
\textsuperscript{38} Id.
\textsuperscript{39} Id. at 437.
\textsuperscript{40} Williams v. Quest Diagnostics, Inc., 816 S.E.2d 564 (S.C. 2018).
\textsuperscript{41} Id.
\textsuperscript{42} Id. at 565.
2019] Misdiagnosis of Quest

included a concise three-page analysis. The Court first highlighted the statutory definition of a health care provider under section 38-79-410 which states that “[l]icensed health care providers’ means physicians and surgeons; directors, officers, and trustees of hospitals; nurses; oral surgeons; dentists; pharmacists; chiropractors; optometrists; podiatrists; hospitals; nursing homes; or any similar category of licensed health care providers.” The Court explained that “[o]ur primary function in interpreting a statute is to ascertain and give effect to the intention of the Legislature.” Before interpreting the statute, the Court echoed established precedent that “the general words are construed to embrace only persons or things of the same general kind or class as those enumerated.” According to the same precedent, general words in the statute are “restricted by words of specification which precede them . . .” Therefore, the Court should have only included things of the same kind or class as the words of specification in the statute so as to not give them unintended meaning. In this case, the Court settled on the specific term “hospitals” to ascertain the meaning of the general term “health care providers.” Unfortunately, the Court separated from the intent of the Legislature and produced an unintended meaning to the statute.

The Court’s reading of the statute failed to include essential analysis and found that “the genetic testing laboratory is performing diagnostic testing at the request of a treating physician for the purpose of diagnosis and treatment, which is a

43. Id. at 564.
44. Id. at 565 (emphasis omitted); S.C. Code Ann. § 38-79-410 (2018).
45. Williams, 816 S.E.2d at 565 (citing Swanigan v. Am. Nat. Red Cross, 313 S.C. 416, 419 (1993)).
46. Id. (emphasis added).
47. See State v. Patterson, 261 S.C. 362, 365 (1973) (“the meaning of [general] words may be restricted by words of specification which precede them on the theory that if the legislature had intended the general words to be used in their unrestricted sense, there would have been no mention of the particular class.”).
48. Id.
49. Williams, 816 S.E.2d at 565.
50. Id.
core function of hospitals in diagnosing and treating patients.\textsuperscript{51} Since Quest was performing diagnostic testing for a physician in a similar manner and for similar purposes, the lab can be considered interchangeable with a hospital.\textsuperscript{52} The Court gave weight to multiple subsections of South Carolina law, the first of which provides an additional definition of hospitals, and the second defines the terms “facility”, “health care provider”, and “health care service.”\textsuperscript{53} These statutes were mistakenly applied to Quest and reveal multiple inconsistencies overlooked by the Court.

In 1993, in \textit{Swanigan v. American National Red Cross}, the Court answered a similar certified question to the contrary, holding that a health care provider must provide care to patients, not just a service.\textsuperscript{54} The Court’s opinion in \textit{Williams v. Quest} does not provide any supporting precedent and overlooks the pertinent certified question analysis used in \textit{Swanigan}.\textsuperscript{55} Moreover, the Court’s breakdown of section 38-79-410 falls short of the standards found in \textit{Swanigan}.\textsuperscript{56} In a closely related matter, the Court in \textit{Swanigan} was asked to answer the certified question of whether a blood bank qualified as a health care provider under section 38-79-410.\textsuperscript{57} Similar to \textit{Williams v. Quest}, the defendant in \textit{Swanigan} attempted to utilize the strict statute of limitations in medical malpractice which would effectively bar the plaintiff’s claim.\textsuperscript{58} The certified question in \textit{Swanigan} confronts the same statute as \textit{Williams v. Quest}, but the methods employed by the Courts in the two cases are contradictory.\textsuperscript{59} Two main distinctions are the \textit{Swanigan} Court implemented multiple decisions from outside jurisdictions and purely compared blood banks to health care providers in their evaluation of section 38-
Unlike in Williams v. Quest, the Swanigan Court used precedent from four other states to guide their interpretation of section 38-79-410. When faced with this novel question in South Carolina, the Court found it necessary to look to other jurisdictions for assistance. Relying on the outside precedent, the Swanigan Court was able to decipher that the key feature of a health care provider is the “care” to patients. The Swanigan Court then shifted their focus entirely on whether a blood bank “provided health care to patients” which would qualify them as a health care provider. The Court held that the “collection and processing of blood does not constitute providing health care to patients.” It is also admitted that the collection and processing of blood is a “medical service,” but was not enough to be considered health care to patients. Therefore, since the facility only provided a medical service and did not care for the patients, it did not qualify as a health care provider.

When applying the Swanigan Court standard, the only question that should be answered in Williams v. Quest is whether Quest provides care for patients, or only a medical service. This was found to be the defining inquiry in Swanigan to establish whether a facility is a health care provider under section 38-79-410. The facility in question in Swanigan, The American Red Cross, provides blood to thousands of hospitals and transfusion centers. The blood is no doubt an important tool used by the

60. Id.
61. Id. (citing holdings from Florida, Maryland, Minnesota, and Wisconsin).
62. Id.
63. Swanigan, 313 S.C. at 419.
64. Id.
65. Id.
66. Id. (citing Doe v. American Red Cross Blood Services, 297 S.C. 430 (1989)).
67. Id. at 420.
68. Id. at 419.
69. Swanigan, 313 S.C. at 419.
hospital in their treatment and care of patients. But the Court in *Swanigan* found that the main duty of the facility was to provide a service, not to care for patients. Likewise, according to a description found on its own website, Quest “offer[s] a wide range of products and services that benefit . . . healthcare providers . . .” The corporation itself declares that not only does it only provide products and services, it provides them to “healthcare providers.” Quest makes no mention of providing care for patients, but that it provides Diagnostic Testing that “. . . doctors need to make better healthcare decisions.” Again the corporation admits that its’ services are used by health care providers, but it does not provide care to the patients. Thus, it is evident that Quest’s diagnostic testing, like the blood provided by American Red Cross, is merely a tool used by health care providers to aid in the treatment of patients.

The *Swanigan* Court utilized precedent from other states and the general terms of section 38-79-410 to produce a workable standard for determining what constitutes a health care provider. The Court in *Williams v. Quest* disregarded the standard set forth in *Swanigan* and instead manipulated the law to fit around their opinion. Once the Court determined Quest is in the same category as hospitals, they concluded that Quest “clearly falls within section 38-79-410’s catchall of ‘any similar category of licensed health care providers.’” Quest is set to benefit from being labeled a health care provider for purposes of medical malpractice in South Carolina.

The *Williams* Court first looked to S.C. Code Ann. § 15-79-110(4) which defines hospital as “a licensed facility with an

71. *Id.*
74. *Id.*
75. *Id.*
76. *Id.*
77. *Swanigan*, 313 S.C. at 419.
78. *Williams*, 816 S.E.2d at 566.
79. *Id.* at 565.
organized medical staff to maintain and operate organized facilities and services to accommodate two or more nonrelated persons for the diagnosis, treatment, and care of such persons . . . “80 The Court cited to the statute as a whole and did not specify which part applied to Quest.81 However, the Court in Swanigan held that “the mere employment of health care professionals is not sufficient to make an employer a ‘licensed health care provider.’”82 Therefore, the Williams Court should not have relied on that aspect of the statute, leaving only the requirement that the facility provide services for the “diagnosis, treatment, and care of such persons.”83 This requirement should fail as well since the Williams Court specified early in the opinion that Quest performing diagnostic testing was for the “purpose of diagnosing and treating patients,” not the care of the patients.84 There is no indication by the Court that Quest was involved whatsoever with the care of patients which is a prerequisite according to section 15-79-110(4).85 It seems obvious that the Legislature intended that the facility be used for “diagnosis, treatment, and care” to be considered a hospital, not two out of three.86 Based on the precedent in Swanigan and the plain intent of the Legislature to require the care of patients, Quest should fail to qualify as a hospital according to the definition provided by section 15-79-110(4).87

At the beginning of the Court’s analysis, the Court reiterated well-established precedent that “[o]ur primary function in interpreting a statute is to ascertain and give effect to the intention of the Legislature.”88 Nevertheless, the Court’s respect

80. Id. (citing S.C. Code Ann. § 15-79-110(4) (2018)).
81. Id.
82. Swanigan, 313 S.C. at 420.
84. Williams, 816 S.E.2d at 565.
85. Id.
86. § 15-79-110(4) (emphasis added).
87. Swanigan, 313 S.C. at 420; See also infra Section IV B.
for the intention of the Legislature waned in the application of S.C. Code Ann. § 38-71-1920. This section is known as the Health Carrier External Review Act (“External Review Act”) and was passed five years prior to the Tort Reform Act of 2005. The External Review Act was created to establish and maintain external review procedures for insurance purposes. The External Review Act was simply to ensure covered persons have an opportunity for independent review of insurance company decisions. There is no indication that the Legislature intended the definitions found in the External Review Act to apply in the determination of a health care provider in the medical malpractice context. Further, the certified question involved the definition of a health care provider under section 38-79-410 which is directly associated with medical malpractice. The Court dangerously strayed too far from the medical malpractice context and relied heavily on far-fetched statutory definitions to assemble a questionable answer.

The Court specifically cited to sections 38-71-1920(7), (11), and (12) and asserted that the statute provides the definition of a health care provider as “an institution providing health care services’ —‘for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease’—‘including, but not limited to, hospitals and . . . diagnostic, laboratory, and imaging centers.’” However, the definition parroted by the Court, most notably the portion emphasized, is primarily found only in section 38-71-1920(7) which defines the term “facility.” It seems clear that the primary purpose of this section was to

89. Williams, 816 S.E.2d at 565.
92. Id.
93. Id.
95. Williams, 816 S.E.2d at 565.
96. Id. (emphasis in original).
97. Id.; “Facility” means an institution providing health care services . . . including but not limited to hospitals and . . . diagnostic, laboratory, and imaging centers . . . ” § 38-71-1920(7).
define facility, not provide a definition of a health care provider in this context.98

The Court utilized the small portion of the definition that mentions diagnostic laboratories and attempted to piece it together with sections 38-71-1920(11) and (12).99 Most importantly, section 38-71-1920(11) defines “health care provider” as “a health care professional or a facility.”100 As stated in the definition, to be considered a facility the institution must “provide health care services.”101 The Court then applied the definition found in section 38-71-1920(12) which includes the “diagnosis . . . of a health condition” as a health care service.102 The fact that Quest assisted in the diagnosis of patients was established early in the Court’s opinion,103 so the Court continued to misconstrue this definition of health care provider to include Quest.104 Regrettably, section 38-71-1920 was enacted to apply to Insurance Law and has little to nothing to do with medical malpractice.105

B. The Differences Between a Diagnostic Lab and a Hospital Far Outweigh the Single Small Similarity

After blending the multiple statutory definitions, the Court determined that “[u]nder the circumstances presented, [Quest] fits within the category provided by one of the specified designations in section 38-79-410, a hospital.”106 The Court reasoned that if the diagnostic test is ordered by a physician, the diagnostic laboratory is in the same class as a hospital.107 The Court emphasized the fact that diagnostic testing is a “core

98. Id. § 38-71-1920(7).
99. Williams, 816 S.E.2d at 565.
100. § 38-71-1920(11).
101. Id. § 38-71-1920(7).
102. Id. § 38-71-1920(12) (“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.).
103. Williams, 816 S.E.2d at 565.
104. Id.
105. § 38-71-1920.
106. Williams, 816 S.E.2d at 565 (emphasis added).
107. Id.
function of hospitals,” but left out several attributes and functions that are unique to hospitals. In coming to this conclusion, the Court did not take into account the applicable decision and analysis found in Swanigan. The Court also discounted the definitions of a hospital provided by outside precedent and multiple state and federal statutes that would expose fundamental dissimilarities between services provided by hospitals and diagnostic laboratories. In response, Justice Hearn authored the lone dissenting opinion and denoted several contrasting features that should have been recognized by the Court.

1. Other States Offer Examples of the Unique Features of a Hospital

Though precedent from outside jurisdictions is not binding to the Court, they provide multiple definitions of hospitals. For example, in Michigan, Mich. Comp. Laws Serv. § 333.20106(5) states that the facility must offer “inpatient, overnight care, and services for observation” to fall under the statutory definition of hospital. In addition, the statute specifies that the patient requires “the daily direction or supervision of a physician.” The facility must offer overnight care and the daily supervision of a physician to be considered a hospital. It is also worth noting that the Michigan Supreme Court also refers to section 333.20106 to determine whether a facility is liable for medical

108. Id.
109. Id.
110. Id.
111. Id. at 566.
113. “Hospital” means a facility offering inpatient, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily direction or supervision of a physician. Mich. Comp. Laws Serv. § 333.20106(5).
114. Id.
115. Id.
Similarly, in Connecticut, there are several defining factors of hospitals that are not found in diagnostic labs. According to Conn. Gen. Stat. § 19a-490, a hospital is “an establishment for the lodging, care and treatment of persons . . . and includes inpatient psychiatric services in general hospitals.” To be licensed as a general hospital, the facility must have inpatient psychiatric services while providing lodging and care for patients. A separate Connecticut statute, Conn. Gen. Stat. § 19a-535(b), defines a “chronic disease hospital” which is “a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases.” Simply, a chronic disease hospital must have the staff and equipment necessary to provide care to patients with chronic diseases. These statutory definitions are applied by the Superior Court of Connecticut for purposes of medical malpractice.

Another factor that is exclusive to hospitals is the 24-hour availability of qualified medical staff that provide care for patients. When combining the specific factors laid out by outside jurisdictions, it is apparent that hospitals are viewed in a much different light than the Court in *Williams v. Quest*. The requirement that a hospital must be able to provide 24-hour care to patients is repeated in numerous jurisdictions. Further, the Montana statute even specifies that the facility medical staff must be on call and available to the patients within 20

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116. See, e.g., Kuznar v. Raksha Corp., 750 N.W.2d 121 (Mich. 2008) (holding that a pharmacy was not a health care facility under section 333.20106).
119. Id. at § 19a-490(b).
120. Id. § 19a-535(b).
121. Id.
123. Id.
Requirements ranging from overnight and 24-hour care to psychiatric and chronic disease treatment are far beyond the Court’s description of the duties of Quest.\textsuperscript{126} In addition to being inconsistent with other states’ definitions of a hospital, the \textit{Williams} decision is not consistent with either federal or state law.

2. Federal and State Law Definitions of a Hospital

Federal law is consistent with the states’ specified attributes that qualify a facility as a hospital.\textsuperscript{127} Though the statute is for Social Security purposes, it reveals yet another alternative definition of hospitals that is far from that of a diagnostic lab.\textsuperscript{128} Under 42 U.S.C.S. § 1395x(e)(1), a hospital must provide “by or under the supervision of physicians, to inpatients . . . diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons . . .”\textsuperscript{129} Once again the supervision of physicians is required for the care of patients; plus, the statute adds the therapeutic services requirement as well.\textsuperscript{130} In addition, the federal law also includes the aforementioned requirement that the facility must provide 24-hour service to patients.\textsuperscript{131} Considering that the said definitions are not within the Court’s jurisdiction, the final interpretation of hospital is found in South Carolina law.\textsuperscript{132} As stated in S.C. Code Ann. § 44-7-130, a hospital should provide “overnight medical or surgical care . . . and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy.”\textsuperscript{133} The common theme of

\begin{itemize}
\item \textsuperscript{125} "A hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week, and provides 24-hour nursing care by licensed registered nurses." Mont. Code Ann. § 50-5-101(31) (2017).
\item \textsuperscript{126} See Williams, 816 S.E.2d at 565.
\item \textsuperscript{127} See 42 U.S.C.S. § 1395x(e) (2018).
\item \textsuperscript{128} \textit{Id}.
\item \textsuperscript{129} \textit{Id.} § 1395x(e)(1).
\item \textsuperscript{130} \textit{Id}.
\item \textsuperscript{131} \textit{Id.} § 1395x(e)(5).
\item \textsuperscript{132} See S.C. Code Ann. § 44-7-130 (2018).
\item \textsuperscript{133} \textit{Id.} § 44-7-130(12) (emphasis added).
\end{itemize}
overnight medical care is once again reiterated as a defining factor of a hospital. Further, the statute asserts that “all” of the diagnosis, treatment, or care is directed by a licensed physician. Though some diagnostic tests are ordered by physicians, as in Williams v. Quest, the tests are also available to the public absent the direction of a physician. Though Quest may provide important services, the Court’s inference that they are in the same category as hospitals is unconvincing.

3. Justice Hearn’s Dissent Identified the Obvious Contrasting Features of a Hospital and a Diagnostic Lab

Justice Hearn is the lone Justice to recognize the distinction between hospitals and diagnostic labs. In doing so, she relied solely on section 38-79-410 and simply compared the health care providers listed to diagnostic labs. Justice Hearn found that “[t]he key commonality among the health care providers listed in the statute is that all function to provide direct, face-to-face treatment to patients, who in their own right conscientiously select these providers and rely on their skill, expertise, and professional judgment.” According to Justice Hearn, all of the health care providers listed in section 38-79-410 provide face-to-face care to patients that have consciously chosen to be treated by that particular provider. Diagnostic labs are not involved in face-to-face care of patients. Justice Hearn goes on to state that the health care providers “make conclusive decisions about a patient’s course of treatment.” Though diagnostic labs provide services to treat and diagnose, health care providers decide the course of care for the patient.

Justice Hearn recognized the Court’s argument that

134. Id.
135. Id.
136. See infra Section V.
137. Williams, 816 S.E.2d at 566 (Hearn, J., dissenting).
138. Id.
139. Id.
140. Id.
141. Id.
142. Williams, 816 S.E.2d at 566 (Hearn, J., dissenting).
diagnostic labs provide a service also found in hospitals, but she found it unavailing: “Although hospitals may contain in-house diagnostic laboratories, I do not believe that fact standing alone is dispositive of whether Quest falls within a similar category of health care provider.”¹⁴⁴ Just because some hospitals have diagnostic labs should not automatically qualify Quest in the same class as hospitals.¹⁴⁵ Justice Hearn maintained that “[w]hile Quest may provide a medical service sometimes available at hospitals, the similarities end there.”¹⁴⁶ Other than the one similar service, hospitals and diagnostic labs have nothing in common.¹⁴⁷ This portion of the dissent is particularly powerful considering it exposed that the Court’s holding was founded on one small similarity.¹⁴⁸

Nearing the end of her dissent, Justice Hearn delivered the final blow to the Court’s opinion: “I do not believe the limited, specialized services offered by Quest are sufficient to render it similar to hospitals, which are holistic enterprises offering a multitude of medical services and treatment options.”¹⁴⁹ Convincingly, she reiterated that a simple analysis of the two facilities shows that hospitals offer all kinds of exclusive services and features that are not found in diagnostic labs.¹⁵⁰ Justice Hearn’s dissent established the inconsistencies in the Court’s opinion and provides a simple explanation.¹⁵¹ Irrevocably, Justice Hearn stated: “I would answer the certified question, ‘No.’”¹⁵² Regardless of her sound reasoning, the Court labeled Quest as a health care provider. From now on, an action against the diagnostic lab will likely fall under the strict requirements of medical malpractice procedures in South Carolina.

¹⁴⁴ Id.
¹⁴⁵ Id.
¹⁴⁶ Id.
¹⁴⁷ Id.
¹⁴⁸ Williams, 816 S.E.2d at 566 (Hearn, J., dissenting).
¹⁴⁹ Id.
¹⁵⁰ Id.
¹⁵¹ Id.
¹⁵² Id.
SECTION III. MEDICAL MALPRACTICE IN SOUTH CAROLINA FAVORS DEFENDANTS

Medical malpractice in South Carolina offers multiple benefits to defendants while forcing the plaintiff to undertake a difficult and usually fruitless lawsuit. South Carolina statutes have exact time limits that can potentially bar a plaintiff's claim and strict requirements that are expensive and time-consuming.153 Defendants, on the other hand, benefit from the mandatory procedures and limitations on plaintiff's recovery.154 The process of filing and the dismal outcomes of medical malpractice lawsuits is normally enough to deter a plaintiff from pursuing a claim at all.155

A. The Distinct Procedures of Medical Malpractice in South Carolina

To fully grasp the issue of Quest being labeled as a licensed health care provider, the formidable task of bringing a medical malpractice lawsuit in South Carolina must be examined. Medical malpractice in South Carolina is defined as “doing that which the reasonably prudent health care provider. . .would not do or not doing that which the reasonably prudent health care provider. . .would do in the same or similar circumstances.”156

One of the components of the Tort Reform Act of 2005,157 S.C. Code Ann. § 15-79-125(A), requires that before the injured party may initiate a medical malpractice action, “the plaintiff shall contemporaneously file a Notice of Intent to File Suit and an affidavit of an expert witness, . . .”158 The statute lists strict requirements for the Notice of Intent to File Suit159 and that the

153. See infra Section III. A.
154. Id.
155. See infra Section III. B.
159. “The notice must name all adverse parties as defendants, must contain a short and plain statement of the facts showing that the party filing the notice is entitled to relief, must be signed by the plaintiff or by his attorney, and must include any standard interrogatories or similar disclosures required by the
expert affidavit must satisfy the requirements of S.C. Code Ann. § 15-36-100. This section, in addition to explaining the qualifications of an expert witness, states in pertinent part that the expert affidavit “must specify at least one negligent act or omission claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit.” If the plaintiff fails to submit an expert affidavit, the affidavit is found to be defective, or the affidavit is not submitted in time, the complaint is subject to dismissal. In essence, the plaintiff must find a qualified expert, solicit their expert opinion, and potentially pay thousands of dollars before they can officially seek judicial relief.

Following service of the Notice of Intent with a valid expert affidavit, the parties are required to participate in a mediation conference. The pre-suit mediation requirement is an additional aspect of the Tort Reform Act of 2005 and is stated expressly in S.C. Code Ann. § 15-79-125(C): “Within ninety days and no later than one hundred twenty days from the service of the Notice of Intent to File Suit, the parties shall participate in a mediation conference.” Mediation is “a method of nonbinding dispute resolution involving a neutral third party who tries to

South Carolina Rules of Civil Procedure.” Id.
160. Id.
162. Id. § 15-36-100(B).
163. Id. § 15-36-100(C)(1)-(2), (D), (E), (F).
164. SEAK, Inc., Expert Witness Fees: How Much Does An Expert Witness Cost?, https://blog.seakexperts.com/expert-witness-fees-how-much-does-an-expert-witness-cost/ (last visited Dec. 20, 2018). According to the 2004 survey, 74% of expert witnesses require an up-front retainer and the median initial retainer fee for an expert witness is $2000. Id. The median hourly fee for file review/preparation for all medical expert witnesses is $350 (43% higher than for non-medical experts). Id.; The Expert Institute provides expert services to attorneys and has surveyed over 20,000 expert engagements with attorneys. The Expert Institute, https://www.theexpertinstitute.com/expert-witness-fees/ (last visited Dec. 20, 2018). The average hourly fees for medical experts for “Initial Review Fees” is approximately $443. Id. These figures represent the average hourly rate charged by medical expert witnesses in any specialty area. Id.
166. 2005 Act No. 32, § 5, eff. July 1, 2005.
help the disputing parties reach a mutually agreeable solution." The reasoning behind mandatory mediation, as interpreted by the South Carolina Supreme Court, is to provide an expedited and effective method to settle meritorious claims while simultaneously ceasing frivolous claims. The circuit court has jurisdiction to enforce the requirements of mandatory mediation and has the authority to sanction a party or even dismiss the party’s claim if they fail to comply with this section. The mediation requirement is yet another obstacle in bringing a medical malpractice lawsuit in South Carolina. Finally, once the party successfully complies with all of the pre-suit requirements found in S.C. Code Ann. § 15-79-125 and the matter fails to be resolved by mediation, the party may then file a summons and complaint.

Along with the arduous pre-filing requirements, one of the most critical characteristics of a medical malpractice action in South Carolina is the statute of limitations. The three-year

170. Ross v. Waccamaw Cnty. Hosp., 404 S.C. 56, 63 (2013) (“It is clear that the Legislature enacted section 15-79-125 to provide an informal and expedient method of culling prospective medical malpractice cases by fostering the settlement of potentially meritorious claims and discouraging the filing of frivolous claims.”).
172. Ross, 404 S.C. at 63.
173. The effectiveness of mandatory mediation is a complex issue that will not be discussed further in this Note. See generally Florence Yee, Note, Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis, 7 Cardozo J. Conflict Resol. 393 (2006) (discussing the advantages and drawbacks of mandating participation in mediation in medical malpractice disputes); Lydia Nussbaum, Mediation as Regulation: Expanding State Governance over Private Disputes, 2016 Utah L. Rev. 361 (2017) (comparing generations of procedural attempts to reform medical malpractice with Oregon’s recently implemented program).
175. S.C. Code Ann. § 15-3-545(A) (2018) (“[A medical malpractice action] must be commenced within three years from the date of the treatment, omission, or operation giving rise to the cause of action or three years from date
The final distinguishing trait of medical malpractice actions in South Carolina are the statutory damages caps that limit the noneconomic damages a plaintiff may recover. Noneconomic damages awarded to a plaintiff are “not to exceed three of discovery or when it reasonably ought to have been discovered, not to exceed six years from date of occurrence.”

176. Id.; Holly Woods Ass’n of Residence Owners v. Hiller, 708 S.E.2d 787, 793 (S.C. App. 2011); Snell v. Columbia Gun Exch., Inc., 276 S.C. 301, 303 (1981) (“. . .an injured party must act with some promptness where the facts and circumstances of the injury would put a person of common knowledge on notice that some right of his has been invaded or that some claim against another party might exist.”).

177. Hiller, 708 S.E.2d at 793.

178. See supra note 56.


182. “Noneconomic damages” means nonpecuniary damages arising from pain, suffering, inconvenience, physical impairment, disfigurement, mental anguish, emotional distress, loss of society and companionship, loss of consortium, injury to reputation, humiliation, other nonpecuniary damages, and any other theory of damages including, but not limited to, fear of loss, illness, or
hundred fifty thousand dollars.” 183 If more than one healthcare provider is found liable, “the limit of civil liability for noneconomic damages for all health care institutions and health care providers is limited to an amount not to exceed one million fifty thousand dollars for each claimant.” 184 The implementation of damages caps was yet another part of the Tort Reform Act of 2005 intended to reform the medical malpractice insurance crisis. 185 Thus, unless an exception applies, 186 South Carolina law constrains each individual plaintiff’s ability to recover noneconomic damages in medical malpractice actions. 187

B. Injured Plaintiffs Face an Uphill Battle from Beginning to End

In a landmark report written by the Institute of Medicine, research showed that roughly 100,000 people die each year from medical negligence. 188 Recently, the number is estimated to be around 250,000 people each year and is the third leading cause of death in the United States. 189 Though the number of deaths is

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184. Id. § 15-32-220(A).
186. § 15-32-220(E) (“[Limitations] do not apply if the jury or court determines that the defendant was grossly negligent, wilful, wanton, or reckless, and such conduct was the proximate cause of the claimant’s noneconomic damages, or if the defendant has engaged in fraud or misrepresentation related to the claim, or if the defendant altered or destroyed medical records with the purpose of avoiding a claim or liability to the claimant”).
187. Id. § 15-32-220.
188. See Institute of Medicine, To Err is Human: Building a Safer Health System (Linda T. Krohn et al. eds., 2000).
189. See Study Suggests Medical Errors Now Third Leading Cause of Death
staggering, multiple studies show that only 1 in 25, a mere 4 percent of patients with a medical malpractice claim actually brought a lawsuit against the health care provider.190 Of the few lawsuits that are brought, only around 7 percent of claims make it to a jury verdict.191 Even in the unlikely event that a medical malpractice claim is decided by a jury, approximately 70 to 90 percent of trials are won by the defendants.192 The low success rates can be associated with medical malpractice claims being the most hotly defended negligence cases,193 and the trend of jury sympathy for health care providers.194

Due to the discouraging rate of success and costs associated with medical malpractice claims,195 it may be difficult for an injured party to find an attorney to pursue a claim at all.196 Generally, in order to find representation, the injured party’s claim must have a certain level of merit.197 If an attorney finds


191. Id.

192. Id. (“Plaintiffs won only 27% of these trials, about one case in four.”); see also AMA Studies Show Continued Cost Burden of Medical Liability System, American Medical Association, https://www.ama-assn.org/press-center/press-releases/ama-studies-show-continued-cost-burden-medical-liability-system (last visited Dec. 3, 2018) (study based on a sample of medical liability claims that closed between 2006 and 2015 found 87.5 percent defendant win rate).


194. See Vidmar, supra note 72 (North Carolina jurists described attitudes as “too many [plaintiffs] want to get something for nothing; and most doctors... should not be blamed for simple human misjudgment...”).

195. See supra Section III A.

196. See Figman, supra note 75 (“A [plaintiff’s] lawyer would be insane to take on a project involving hundreds, if not thousands of hours of unpaid time, with the concomitant need to invest tens of thousands of dollars, if the case was a frivolous one.”).

197. Id.
that the claim has value, or there is sufficient evidence of error on the part of the potential defendant, they are more likely to consider taking the case.\textsuperscript{198} Even if an attorney decides to pursue a claim against a health care provider, in claims that involve disputed liability, one study shows that plaintiffs received a significant award of damages in only 11 percent of the cases.\textsuperscript{199} After countless hours of work and thousands of dollars spent, it is probable that the injured party leaves the courtroom with an insignificant award for their damages.\textsuperscript{200}

At large, the development and pursuit of a medical malpractice claim has proven to be a laborious and expensive feat that is rarely won by the claimant.\textsuperscript{201} This harsh reality is compounded in South Carolina by the unique procedural and precedential requirements for medical malpractice claims.\textsuperscript{202}

SECTION V. CONCLUSION

Notwithstanding the plentiful amount of definitions and opinions that directly contradict the Court’s analysis, the Court found that Quest is a health care provider.\textsuperscript{203} Quest is poised to benefit immediately from this answer in Williams’ wrongful death lawsuit against them. After the Court’s answer, \textit{Williams v. Quest} moved forward in District Court.\textsuperscript{204} As expected, once Quest was labeled a health care provider, the corporation immediately filed a supplemental brief that included a Rule 12(b)(6) motion to dismiss.\textsuperscript{205} The motion is premised on the fact that Quest is now a health care provider under section 38-79-410.

\begin{footnotesize}
\begin{enumerate}
\item[	extsuperscript{198}.] \textit{Id.}; \textit{See also} David M. Studdert, et al., \textit{Claims, Errors, and Compensation Payments in Medical Malpractice Litigation}, N. Eng. J. Med. 2006; 354:2024-33 (finding that most injuries with evidence of error were compensated).
\item[	extsuperscript{200}.] \textit{Id.}
\item[	extsuperscript{201}.] \textit{See supra} Section III.
\item[	extsuperscript{202}.] \textit{See supra} Section III A.
\item[	extsuperscript{203}.] 816 S.E.2d at 566.
\item[	extsuperscript{204}.] \textit{William v. Quest} Diagnostics, Inc., 2018 U.S. Dist. LEXIS 179229 at *1.
\item[	extsuperscript{205}.] \textit{Id.} at *8.
\end{enumerate}
\end{footnotesize}
therefore the six-year statute of repose found in section 15-3-545(A) applies to Williams’ claim.\footnote{206} Quest argues that all of Williams’ claims\footnote{207} “are predicated on the alleged misdiagnosis of Decedent’s medical condition in 2007” which qualifies as medical malpractice.\footnote{208} If the judge agrees, Williams’ claim would be barred by the statute of repose and Quest would be released from liability.\footnote{209} Senior U.S. District Judge Seymour decided that the matter should proceed to discovery, but also adds that Quest can renew their argument on motion for summary judgement.\footnote{210}

Third party diagnostic labs like Quest will be able to exploit the advantages bestowed on health care defendants by South Carolina law. Plaintiffs that are injured by the corporation more than six years prior to bringing the suit will be forever barred from recovery.\footnote{211} Billion-dollar corporations will potentially escape liability simply because they happen to provide one service that is also provided by hospitals. When bringing a claim against a corporation like Quest, plaintiffs now must follow the medical malpractice procedures in South Carolina. The expensive, daunting, and seemingly impossible process will deter injured parties from ever pursuing a claim.\footnote{212} Even if the corporation is found liable, the damages caps will limit the amount that can be recovered by the plaintiff.\footnote{213} Quest, and similar diagnostic labs, are part of an industry that is expected to exceed approximately $150 Billion in the next five years.\footnote{214} Applying medical malpractice damages caps to these corporations inflates their lucrative profits and robs an injured plaintiff of his potential recovery.

\footnote{206} Id. at *10.  
\footnote{207} Id. at *10.  
\footnote{208} Id. at *10.  
\footnote{209} Id. at *10.  
\footnote{210} Id. at *10.  
\footnote{211} Id. at *10.  
\footnote{212} Id. at *10.  
\footnote{213} Id. at *10.  
\footnote{214} See supra Section III B.  

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The relevant medical malpractice statutes were included in the Tort Reform Act of 2005 in response to the medical malpractice crisis. Certainly the Legislature did not intend corporations that provide a single medical service to be protected as if it were a hospital. The Court seemed to purposefully stay within a state of obliviousness to come up with a pre-determined answer. Diagnostic labs should have never been put in the same category as hospitals. Plaintiffs that are injured by diagnostic labs like Quest should not be required to take on the incredible undertaking of a medical malpractice action just because the lab has a single similarity to hospitals. Even more disturbing is the fact that the diagnostic laboratory industry is growing rapidly, and the Court presented the labs with a way to avoid liability. The Court’s finding has the potential to rob plaintiffs of their right of redress against billion-dollar corporations like Quest. In order to bring effect to Legislative intent and expunge diagnostic labs as health care providers, the Court must re-evaluate and overrule the decision in *Williams v. Quest*.

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