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# Kentucky Law Survey: Medical Malpractice

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# Medical Malpractice

BY R. DAVID CLARK*

In a 1971 stratified national sample of American physicians, "malpractice suits" were identified as the third "most pressing problem" confronting health care in the United States.[1] This concern is exemplified in the following comment:

> As a physician, I live in an aura of fear—fear of suit. Fear contributes to hostility and rarely contributes to constructive action. Medicine has some bad doctors and some bad health care institutions. We are not proud of them, and we are concerned with the correction or elimination of that element . . . . The house of medicine, however, feels belabored. Medical organizations are trying their best to overcome their deficiencies, but in my opinion medical malpractice litigation is not the best incentive to improvement. It places medicine in an adversary position from which hostilities too often result.[2]

While substantial dissention exists as to the necessity of malpractice litigation,[3] the volume of such cases nationally has increased each year.[4] For example, the number of cases opened nationally in 1970 was 10.6 percent greater than the number closed that year.[5]

Accompanying the increased volume of claims was a similar increase in the liability premiums of health care providers.[6] In 1974 the physicians in at least seven states encountered the

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[1] S. STRICKLAND, U.S. HEALTH CARE: WHAT'S WRONG AND WHAT'S RIGHT 41 (1972).

[2] U.S. DEPT. OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE at 105-06 (1973) (statement of George Northrup, D. O.) [hereinafter cited as HEW REPORT].

[3] *See* SUBCOMMITTEE ON EXECUTIVE REORGANIZATION OF THE SENATE COMMITTEE ON GOVERNMENT OPERATIONS, STUDY ON MEDICAL MALPRACTICE: PATIENT VERSUS THE PHYSICIAN, 91st Cong., 1st Sess. (1969).

[4] HEW REPORT at 7-8.

[5] *Id.* at 7. In the United States, claims asserted against hospitals grew in the period 1967 to 1970 by more than 75 percent, increasing from 1.026 to 1.862 claims per hospital per year. HEW REPORT, app. at 610.

[6] HEW REPORT at 13. Premiums rose nationally for dentists by 115 percent between 1960 and 1970; for hospitals, 262.7 percent; for physicians other than surgeons, 540.8 percent; and for surgeons during the period, 949.2 percent.

prospect of being unable to renew insurance coverage upon its expiration.[7] That year the cost and availability of malpractice liability coverage in Kentucky reached a situation of crisis proportion.[8] A committee was appointed by the Governor of Kentucky in 1975 to recommend legislative solutions to the critical condition of the insurance market for health care providers.[9] In March of 1976, portions of the legislative recommendations of the majority report of that committee were enacted by the General Assembly as the Medical Malpractice Insurance and Claims Act[10] and the Joint Underwriting Association Act.[11]

In addition to the legislative enactments, the Supreme Court of Kentucky has recently decided several cases involving health care providers. Included within the decisions of the past survey period were issues pertaining to informed consent,[12] the liability of a supplier of blood for serum heptatitis,[13] and a surgeon's liability for failure to remove a sponge during surgery,[14] as well as other areas.[15]

## I. MEDICAL MALPRACTICE INSURANCE AND CLAIMS ACT

The Kentucky Medical Malpractice Insurance and Claims

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[7] Wall Street Journal, Dec. 30, 1974, at 10, col. 4 (statement of H.E.W. Secretary Casper W. Weinberger).

[8] Brief for Defendant at 2-3, Hall v. McGuffey and Floyd v. McGuffey, Civil Nos. 86997 and 87037 (consolidated cases) (Ky. Franklin Circuit Court, Sept. 27, 1976) [hereinafter cited as Brief for Defendant]. In 1974 a premium rate increase of 282 percent was proposed to the Commissioner of Insurance of Kentucky for hospital liability insurance. When only a 150 percent increase was approved, a major hospital insurance carrier withdrew from the state. In 1975 the remaining carriers doing business in Kentucky sought an additional 200 percent increase.

[9] *Id.* at 4.

[10] *Id.* at 4-5; KY. REV. STAT. §§ 304.40-250 to -330 [hereinafter cited as KRS]; GOVERNOR'S HOSPITAL AND PHYSICIANS PROFESSIONAL LIABILITY INSURANCE ADVISORY COMMITTEE, REPORT TO THE GOVERNOR, § I [hereinafter cited as GOVERNOR'S REPORT]. Not included in the Kentucky Medical Malpractice Insurance and Claims Act [hereinafter cited as the Act] but recommended by the majority of the Committee were the following provisions: a section eliminating punitive damage claims in malpractice actions; a section revising the statute of limitations for assertion of a malpractice claim; a limitation on attorney contingency fees; and a provision shifting the res ipsa loquitur evidentiary presumption.

[11] KRS §§ 304.30-010 to 304.40-140.

[12] Holton v. Pfingst, 534 S.W.2d 786 (Ky. 1975).

[13] McMichael v. American Red Cross, 532 S.W.2d 7 (Ky. 1975).

[14] Laws v. Harter, 534 S.W.2d 449 (Ky. 1975).

[15] Southeastern Kentucky Baptist Hospital, Inc. v. Bruce, No. 75-469 (Ky. June 11, 1976) (per curiam).

Act [hereinafter cited as the Act] was promulgated to alleviate an emergency relating to "the availability and cost of health care malpractice liability insurance."[16] The express purposes of the Act are to adopt reforms in medical malpractice claims, establish a patients' compensation fund to increase the availability and lower the cost of medical liability insurance, and assure that medical malpractice judgments and settlements are satisfied.[17] However, the expressed basis and purposes do not reveal the diverse areas encompassed by the Act. It not only provides for a patient's compensation fund,[18] but also includes procedural and substantive standards for medical malpractice litigation as well as a procedure to determine the fitness for practice of any health care provider against whom a settlement or judgment has been obtained.[19]

A. *Patients' Compensation Fund*

The Patients' Compensation Fund[20] [hereinafter cited as the Fund] is an agency established within the Department of Insurance. It is expressly charged to promulgate regulations necessary to implement and manage the Fund,[21] and every physician licensed and practicing in the state and every hospital located within Kentucky is required to become a member of the Fund unless exempted by the Commissioner of Insurance.[22] However, an exemption to participation in the Fund does not eliminate or reduce any legal liability incurred by the health care provider.[23] An exemption may be granted to a phy-

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[16] Ky. Acts ch. 163 preamble and § 1(I)(1976).

[17] *Id.* at § 1(I). An argument can be advanced that the third legislative intent, to assure satisfaction of malpractice claims, is merely an incidental benefit of the Act. In the absence of a showing that the medical community has failed to satisfy merited claims, why should the legislature adopt procedures that guarantee payment of unlimited sums? Why should the victim of medical malpractice be categorized separately from victims of other tortfeasors? An explanation may be contained in the previously cited trial brief of the Commissioner of Insurance. In 1974 and 1975 the availability of liability coverage was diminishing. "While most companies did continue to carry the physicians and hospitals they had previously insured, these companies were not willing to write new malpractice insurance . . . ." Brief for Defendant at 3-4.

[18] KRS § 304.30-330.

[19] KRS §§ 304.40-270 to -320.

[20] KRS § 304.40-330(1).

[21] *Id.*

[22] KRS § 304.40-330(2).

[23] CABINET FOR PUBLIC PROTECTION AND REGULATION, DEPARTMENT OF INSURANCE OF

sician licensed in Kentucky only where the physician is not practicing within the state,[24] his practice is confined to performing duties on behalf of agencies of the federal government,[25] his practice is confined to the status of "full-time employee" of the state,[26] or his practice is so limited or is conducted under such special circumstances that he should not reasonably be required to participate in the Fund.[27] Hospitals owned and operated by the United States are exempted from participation[28] as well as hospitals owned and operated in the state "on other than a fee for service basis . . . if the liability for injury to patients injured in such hospitals is determined solely by the State Board of Claims provided for in KRS § 44.070."[29]

Each member of the Fund is required to obtain liability insurance of at least $100,000 per occurrence and $300,000 in the aggregate for all claims occurring during any policy year.[30] In addition, each member must pay an annual assessment to be determined by the Commissioner of Insurance within limits prescribed by the Act.[31] The assessment is collected by the insurance carrier of each member and is paid over to the Fund within 30 days of collection.[32]

The Fund may expend the monies collected by assessment for payment of an approved malpractice settlement or judgment against the health care provider which is in excess of the coverage required by the Act.[33] The manner of payment is outlined in the Act.[34] In the event a claimant obtains an approved settlement or judgment in excess of the primary coverage of

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KENTUCKY, REGULATION § 2(1) (June 30, 1976) [hereinafter cited as REGULATION].

[24] *Id.* § 2(1)(a).

[25] *Id.* § 2(1)(b).

[26] *Id.* § 2(1)(c).

[27] *Id.* § 2(1)(d).

[28] Id. § 2(2)(a).

[29] *Id.* § 2(2)(b).

[30] KRS § 304.40-330(3).

[31] KRS § 304.40-330(5).

[32] KRS § 304.40-330(5)(b).

[33] KRS § 304.40-330(7)(a)-(b). Malpractice is defined by the Act as any tort or breach of contract based on health care or professional services rendered, or which should be rendered, by a health care provider to a patient. *Id.* § 260(6). A tort is any legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury. KRS § 304.40-260(5).

[34] KRS § 304.40-330(8).

$100,000, a claim must be filed against the Fund for payment of the excess.[35]

The regulations of the Fund prescribe the manner of application for approval of a settlement. When a negotiated settlement is achieved or a final judgment is obtained and payment of the settlement or satisfaction of the judgment is dependent upon a payment by the Fund, a joint petition for approval of payment is to be submitted by the insurer and the claimant.[36] The regulations specify the information to be included in the petition as well as a procedure for reporting settlements and judgments not involving payment by the Fund.[37]

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[35] KRS § 304.40-330(8)(b)-(c).

[36] REGULATION §§ 6(3),(4) and (5).

(b) A claimant who has recovered a final judgment or an approved settlement against a health care provider who is covered by the fund shall file a claim with the fund to recover that portion of such judgment or settlement which is in excess of one hundred thousand dollars ($100,000). In the event the fund incurs liability exceeding one million dollars ($1,000,000) to any person under a single occurrence, the fund shall pay not more than one million dollars ($1,000,000) per year until the claim has been paid in full.

(c) Claims filed against the fund shall be paid in the order received within ninety (90) days after filing, unless appealed by the fund. If the fund does not have sufficient money to pay all of the claims, claims received after the funds are exhausted shall be paid out of the general fund of the Commonwealth upon certification of the obligation by the commissioner of insurance to the commissioner of the executive department for finance and administration. Any such funds drawn from the general fund shall be repaid with interest at the legal rate by the Kentucky patient's compensation fund at the earliest practical time as determined by the commissioner of insurance.

[37] The regulation specifically provides in part:

(3) When the insurer of any member or any self insured member has negotiated what it believes to be a reasonable settlement of the claim or is required to satisfy any final judgment thereon, the insurer or self insured shall, if the payment of such settlement or satisfaction is dependent upon any payment by the Fund, jointly with the Claimant petition the Commissioner for approval of such settlement. Such petition shall briefly state the alleged facts on which the claim for malpractice is based, the name and address of the injured party, the nature and extent of injury sustained, the type and amount of damages alleged and the amount and terms of the proposed compromised or negotiated settlement. The Commissioner shall approve such settlement and order the payment of the Fund's proportionate share only if he is satisfied that the settlement is fair and reasonable under all the circumstances and in the best interest of both the Claimant and the member, or is in satisfaction of a final judgment obtained by the Claimant against the member.

(4) In the event a settlement shall be proposed by an insurer and a

In evaluating the amount of funding required, several factors were considered. The Act is applicable only to malpractice occurring after July 1, 1976.[38] A survey of the rating experience of principal malpractice insurance carriers doing business in Kentucky indicated that had the Fund been in existence during the last 3 years, the total claims against it would have averaged $580,000 per year.[39] Because it is anticipated that several years will transpire before any claim could be brought affecting the Fund, $3 to $4 million should accumulate in the Fund through assessment before any volume of claims require payment.[40] It is also anticipated that any inadequacy of funding will be corrected by the legislature.[41]

In addition to this umbrella coverage provided by the Fund for claims in excess of the primary coverage required by the Act, the Commissioner is permitted to supply primary liability coverage to any health care provider within the Fund who is unable to acquire the coverage required by the Act "at a premium of no greater than three hundred percent of the aver-

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Claimant, and the Commissioner shall approve such settlement, then if such settlement is rejected by the member of the Fund, the Fund shall be indemnified by the member for the amount of any judgment in excess of the Fund's liability for the rejected settlement and the costs of defense incurred after rejection of the settlement offer.

(5) Every insurer on behalf of its insured members, or self insured member on its own behalf, shall report to the Commissioner within 60 days of the date on which it makes a final settlement or a final judgment is entered against it on any claim in an amount less than that requiring approval by the Commissioner or payment by the Fund, which report shall contain the information required in a petition for settlement approval, as set forth in sub-section (3) of this section, except that the Claimant need not join therein.

[38] *Id.* § 11.

[39] GOVERNOR'S REPORT § II at 7-8.

[40] *Id.* at 8.

[41] Even assuming that the amount of malpractice awards subsequent to July 1, 1976, would double, or even triple, there would be adequate reserves in the Patient's Compensation Fund [hereinafter cited as the Fund] for the payment of the awards. In the unlikely event that a series of enormous awards would occur that would exceed reserves set up in the Fund, the Act provides for backup funding from general state revenues in the form of loans, to be repaid to the General Fund with interest . . . .

Because of the difficulty of prognosticating the long-range future of malpractice awards, the proposed Act grants to the Commissioner of Insurance discretion in the assessments up to the limits specified. It is reasonable to project that in the first 2 years of activity methods of funding must be obtained, that situation can be resolved by the legislature at its 1978 or 1980 session. *Id.* at 8-9.

age premium then charged for risks of the same class and experience . . . ."[42] However, the ability of the Fund to perform as a primary coverage carrier is curtailed by several limitations contained in the Act, among which is a provision that "[t]he number of health care providers which the Commissioner may accommodate under this section shall not exceed ten (10) in any one (1) year."[43]

As noted above, the Governor of Kentucky appointed a committee in 1975 to recommend legislative solutions to the malpractice insurance crisis. That committee offered both a majority and minority report regarding the Act with sharply differing conclusions regarding the Fund.[44] The majority offered this opinion:

> The result of the establishment of the Patients' Compensation Fund will primarily be the removal of the need for physicians and hospitals to carry very expensive umbrella coverage, and will also reduce the amount of their basic coverage to $100,000/$300,000. This should provide a climate wherein private malpractice insurance carriers will be more willing to participate in the Kentucky market. In regard to physicians teaching and practicing at the University of Kentucky Medical Center and in other publicly-owned institutions, there will be a substantial saving in tax dollars currently expended or reserved for malpractice insurance with the existing high limits of coverage.[45]

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[42] KRS § 304.40-330(6).

[43] *Id.* The complete section provides:

> If the commissioner determines that a health care provider is unable to acquire the professional liability insurance required by subsection (3) of this section at a premium no greater than three hundred percent (300%) of the average premium then charged for risks of the same class and experience, or at all, and such health care provider is unable or unwilling to qualify as a self-insurer, then the commissioner may provide to such health care provider coverage within the fund for the first one hundred thousand dollars ($100,000) per occurrence and three hundred thousand dollars ($300,000) in the aggregate for all claims occurring in any one (1) policy year, and the commissioner may designate an insurance carrier to act as the servicing carrier for such health care provider and charge as a premium therefor an amount to be determined by the commissioner which shall not exceed three hundred percent (300%) of the average premium then charged for risks of the same class and experience. The number of health care providers which the commissioner may accommodate under this section shall not exceed ten (10) in any one (1) year.

[44] GOVERNOR'S REPORT § II, at 9-10, and § V, at 5-6.

[45] *Id.* § II, at 9-10.

The minority report criticizes the "unrealistically" low limitation of personal liability of those participating in the Fund.[46] They argue that the purpose of the Fund should be to provide protection for "the usually high judgment as opposed to any six-figure judgment."[47] The minority is also critical of the manner in which the Fund is financed:

> The Fund as proposed by the Majority Report requires assessments against the participants in advance of the Fund ever being called upon to make a payment. We think that an alternate, better method for dealing with the same problem is to require no advance assessments of participants, but provide that when and if funds are ever needed, assessments should then be made at the time when funds are needed to meet a judgment. Why should physicians be fixed with payments to provide for a Fund which may never been needed? The cost would surely just be passed on to the patient.[48]

In spite of these criticisms, the majority position was subsequently adopted.

B. *Ad Damnum Clause*

The Act provides that in an action for malpractice the ad damnum clause or prayer for damages shall not state any sum as alleged damages other than an allegation that the damages are in excess of the requisite minimum to establish jurisdiction.[49] However, the trier of fact may be advised by the parties "as to what amounts are fair and reasonable as shown by the evidence."[50] This innocuous section is designed to eliminate from the malpractice complaint a demand "far in excess of those which are shown in the evidence" since an excessive demand is "unfair to the health care provider named therein as a defendant because [he is cast] in an unfavorable light before the general public."[51] However, an indirect and unstated purpose of the section appears to be an attempt to reduce the size of jury awards indirectly.

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[46] *Id.* § V, at 5.
[47] *Id.* at 6.
[48] *Id.*
[49] KRS § 304.40-270.
[50] *Id.*
[51] GOVERNOR'S REPORT § II, at 2.

Other jurisdictions have attempted an alternative solution to reach the same result by substantively limiting the amount of recovery. When the Idaho state legislature attempted this, the statute was declared to be an unconstitutional limitation.[52] The Kentucky approach is intended as an indirect avenue for reducing the severity of malpractice awards and the concomitant rise on malpractice insurance premiums. Indeed, it is the only constitutionally permissible way to accomplish this objective in Kentucky.[53]

The specific dollar amount in an ad damnum clause in a complaint serves no significant legal function other than asserting jurisdictional amount, and its elimination removes a needless irritant to the medical profession. Even if its abolition proves to have no effect on the size of jury awards, its elimination will not be disadvantageous to anyone.

C. *Statute of Frauds*

Prior to the adoption of the Act, an oral express warranty of cure by the health care provider could be effective to bind the provider to the warranty. However, its enforcement would depend upon the facts of the individual case.[54] In contrast, the Act directs that no liability for malpractice may be imposed on the basis of an alleged breach of guarantee, warranty, or contract or assurance of results of treatment unless it is in writing and signed by the provider.[55]

This section is designed to eliminate the "growing tendency of plaintiffs to claim an oral guaranty, warranty, contract or assurance of results."[56] Its effect is to remove an avenue of potential malpractice recovery. In an imperceptible degree this does perhaps correspond with the legislative goal of reducing the rate of growth of malpractice premiums. However, the minimal benefit of this section does not appear to justify its enactment in light of the possible abuses.

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[52] IDAHO CODE § 39-4204 (1975) established a $500,000 ceiling limitation which was held unconstitutional in Jones v. State Board of Health, Civil No. 55527 (D. Idaho, September, 1975).

[53] *See* KY. CONST. § 54.

[54] Hackworth v. Hart, 476 S.W.2d 377, 381 (Ky. 1971).

[55] KRS § 304.40-300.

[56] GOVERNOR'S REPORT § II, at 4.

D. *Reporting of Claims*

Before the promulgation of the Act, no procedures existed for collecting information concerning malpractice claims or for notifying licensing agencies of such claims.[57] The Act requires that all malpractice claims against a health care provider settled or adjudicated to final judgment must be reported to the Commissioner of Insurance by the affected carrier.[58] The report must be made within 60 days of final disposition of the claim and must recite the name and address of the involved provider, the name and address of the claimant, the nature of the claim, the items of alleged damage, and the amount of the settlement or judgment.[59] One purpose of this section is to make specific information available to the Commissioner to permit him "to have ready access to all pertinent information which will have a bearing on insurance premiums and other matters regarding malpractice carriers."[60]

The Commissioner of Insurance is directed by the Act to forward the name of every provider against whom a settlement or judgment is made to the "appropriate licensure board or regulatory agency for review of the fitness of the health care provider to practice his profession."[61] While the Act requires submission of the provider's name, the regulations of the agency direct that a monthly report is to be provided to the proper licensing authority containing a "summary of the information" obtained by the Commissioner.[62] The Act does not contain any directives to any medical licensure authority requiring a review of the submitted information, and as a result, the accomplishment of this stated purpose may be in doubt.

E. *Informed Consent*

In 1975, the Kentucky Supreme Court addressed the issue of informed consent for the first time in the case of *Holton v. Pfingst*.[63] Holton alleged a failure by the appellee, Pfingst, an

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[57] *Id.*
[58] KRS § 304.40-310(1).
[59] *Id.*
[60] GOVERNOR'S REPORT § II, at 5.
[61] KRS § 304.40-310(2).
[62] REGULATION § 6(6).
[63] 534 S.W.2d 786 (Ky. 1975).

ophthalmologist, to disclose the risks of a proposed surgical procedure properly.[64] The trial court directed a verdict in favor of the physician, and on appeal the plaintiff argued:

> . . . [S]he consented to such procedure without being fully informed of the nature and possible consequences when in fact she would not have done so had she been fully informed.
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> . . . .
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> . . . [T]he evidence is clear and unmistakable that had appellant been informed of a possible grave hazard or a possible result which would cause loss of vision or damage to the eye, she would not have had the operation performed. . . .[65]

The appellant in effect argued a "material risk" approach to the issue of informed consent, the essence of which is that the adequacy of the physician's disclosures to the patient should be measured by the patient's need for information material to the risks involved.[66] Thus the issue under the material risk doctrine is framed as whether the physician's disclosures to the patient regarding a proposed procedure were sufficient and material to the informative needs of the patient, acting as a reasonable person, in deciding whether to grant or withhold consent to the procedure.

In contrast, the defendant physician urged a "medical standard" approach upon the Court, relying in part on *Wilson v. Scott*,[67] wherein the court stated:

> We conclude therefore that the plaintiff had the burden to prove by expert medical evidence what a reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment, that the physician departed from that standard, causation, and damages. The action is one of malpractice for a physician's failure to conform to medical standards in obtaining the patient's consent. Regardless of what

[64] *Id.*

[65] Brief for Appellant Holton at 13, 15-16, Holton v. Pfingst, 534 S.W.2d 786 (Ky. 1975).

[66] *See* Canterbury v. Spence, 46 F.2d 772 (D.C. Cir. 1972).

[67] 412 S.W.2d 299 (Tex. 1967).

some earlier informed consent cases suggest, such an action need not be pleaded as one for assault and battery.[68]

The Court found it unnecessary to adopt either the material risk or medical standard approach completely in deciding *Holton v. Pfingst.*[69] Apparently aware of the impending codification of an informed consent standard, the Court skirted the determination by simply commenting:

> In the instant case, we are persuaded that it is unnecessary to determine whether expert evidence should be required in all instances where the claim is lack of informed consent . . . . In the present case, it is undisputed that the physician's examination and diagnostic procedures were in accordance with acceptable medical practice at the time he made them. . . . There is no evidence, lay or expert, that he failed to disclose that which he knew or should have known. His conduct was such that giving the plaintiff's evidence all favorable inferences to her that could be drawn from it, he was guilty, if anything, of only an honest mistake in judgment.[70]

Despite the Court's disinclination to declare the appropriate standard in dealing with informed consent, the Legislature proved more willing to make an attempt.[71] However, the standard provided in the Act did very little to clarify the issue. Under the Act, in a malpractice action wherein the claimant's informed consent is an issue, informed consent is deemed to have been given if the health care provider obtained the consent in acccordance with accepted medical standards among members of the profession of similar background, and a reasonable individual would understand from the provider's disclosures, the procedure, acceptable alternatives, and the substantial risks inherent in the proposed treatment or procedure.[72] The Act also provides that in an emergency, where consent of the patient cannot be obtained, there is no requirement that prior consent be secured.[73]

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[68] *Id.* at 302; Brief for Appellee Pfingst at 14, Holton v. Pfingst, 534 S.W.2d 786 (Ky. 1975).

[69] 534 S.W.2d 786 (Ky. 1975).

[70] *Id.* at 789.

[71] KRS § 304.40-320.

[72] *Id.*

[73] *Id.*

The result is that the Act embodies a combination of the material risk and the medical standard approach to informed consent. Where the facts are in dispute at least two questions must be posed to the jury: Does the disclosure of the defendant-health care provider conform to accepted medical standards among providers of similar background, and would a reasonable man understand from the disclosures the proposed procedure, its substantial risks, and acceptable alternatives?

In addition to being a hybrid approach, the informed consent provision of the Act is conceptually inconsistent with the express purposes of its drafters. The majority report of the Governor's Hospital and Physicians Professional Liability Insurance Advisory Committee, which substantially drafted the Act, indicates that the informed consent provision is designed to require that informed consent be proven by expert testimony as to standards of the profession, and that an objective standard be applied in determining whether additional information would have resulted in a different decision by the plaintiff.[74] The report concludes that the provisions will prevent jury speculation regarding whether the patient should have been advised of a given risk even though accepted professional standards would not require it and that the provision will prevent the plaintiff from submitting testimony that he would have declined the surgery had he had additional information.[75] Since the provision embodies both the material risk and medical standard approach, it places greater evidentiary burdens upon the defendant physician than those physicians would experience had the legislature enacted either the material risk *or* the medical standard approach. While the committee submitted the provision as a limitation on jury speculation, the section actually invites jury determination of the understanding of the material risks by a reasonable man. Rather than serving as an indirect limitation upon physician liability and malpractice premium increases, the provision creates additional evidentiary burdens and jury issues. In addition, the provision contains language requiring appellate decision; for example, whether "substantial risk" is intended as a measure of the

[74] GOVERNOR'S REPORT § II, at 5.

[75] *Id.*

probability of the risk or the severity of the risk, and whether the definition is influenced by the predictability or preventability of the risk. The informed consent provision of the Act will no doubt provide a source of future appellate controversy.[76]

### F. *Constitutionality of the Act*

In the consolidated actions of *Hall v. McGuffey* and *Floyd v. McGuffey*,[77] a declaratory judgment was sought regarding the constitutionality of several provisions of the Act.[78] The Act was assailed as being violative of no less than twenty sections of the Kentucky Constitution and several provisions of the United States Constitution.[79]

While it is beyond the purview of this paper to review each constitutional challenge, the provisions of the Act called into question by the trial court merit review.[80] The court ruled in part:

> We have no constitutional trepidation concerning the majority of the provisions of the Act.
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> . . . .
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> . . . There is no doubt the practice of medicine and the operation of hospitals [which] affect the health and welfare of the public, are subject to regulation and within the polic power of the sovereign. However, that power should not extend beyond the public's interest in promoting health, safety, welfare or morals. The requirement of maintenance of insurance upon penalty of loss of license extends beyond the pale of accepted regulations. Absent a showing that physicians or hospitals are financially irresponsible or unwilling to satisfy claims made against them such a requirement is unreasonable and violative of the due process clause of the Fourteenth Amendment.
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> . . . .
>
> . . . Whether the practice of medicine be classified a property right or a privilege it may not be unreasonably inter-

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[76] *See* Comment, *Informed Consent in Kentucky*, *infra* p. 524.

[77] Consolidated Civil Action Nos. 86997 & 87037 (Franklin Circuit Court, Kentucky, September 27, 1976).

[78] *Id.* at 1 of Judgment.

[79] *Id.* at 3 of Opinion.

[80] At the date of this writing no appeal of the Franklin Circuit Court decision has been filed; nevertheless such an appeal is certain.

fered with unless it is done to protect the public interest. The practice of medicine is a lawful, honorable and necessary profession. It is presently subject to state regulation. To impose upon this class the responsibility for curing the ills recognized in the preamble to the Act, without an attendant finding of responsibility for such ills is unreasonable. The individual's right to earn a livelihood and the public's right to be administered [to] is being stripped away. Such deprivation is a taking in violation of the Fifth Amendment to the United States Constitution and Section 13 of the Kentucky Constitution and there is a denial of due process and contra to both Sections 2 and 3 of the Kentucky Constitution.

. . . .

. . . The other constitutional infirmity lies in Section 10(8)(c). Referring to the Kentucky patients compensation fund that section provides ". . . claims received after the funds are exhausted shall be paid out of the general fund of the Commonwealth. . . . Any such funds drawn from the general fund shall be repaid. . . ." This section of the Act in fact and in spirit transgresses several sections of the Constitution.

. . . By obligating the general fund of the Commonwealth, a debt of the state is created. Future revenues are committed. The payment of a compensation fund claim from the general fund is payment of a private claim, a special privilege. No less than six sections of the Kentucky Constitution are violated by this section of the Act, Kentucky Constitution Sections 49, 50, 58, 3, 171, 177 and perhaps others.[81]

Defenders of the Act contend that the requirement of malpractice liability coverage and participation in the fund is a valid exercise of the police power of the sovereignty[82] similar to the requirement that automobile owners carry liability insurance.[83] It falls within the province of the legislature to assimilate and consider all factors inherent to the concept of public welfare. If the issues involve the public welfare, then the adjustments are solely within the province of the legislature

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[81] *Id.* at 3-6 of Opinion.

[82] *Id.* at 8 of Brief for Defendant McGuffey; *see* Roe v. Commonwealth of Kentucky, 405 S.W.2d 25 (Ky. 1966), Workmen's Compensation Board v. Abbott, 278 S.W. 533 (Ky. 1925), State Racing Commission v. Latonia Agricultural Ass'n, 123 S.W. 681 (Ky. 1909).

[83] *Id.* at 10 of Brief for Defendant McGuffey; *see* KRS § 304.39-110.

through the police power.[84] Proponents of the Act also assert that any transfer of monies from the general fund of the Commonwealth to the Patients' Compensation Fund is constitutional. As argued, it does not create an indebtedness in violation of the Kentucky Constitution but should be viewed as a constitutional appropriation to a state agency to be refunded by that agency pursuant to the Act.[85]

The constitutional issues framed by the Act and its opponents must necessarily be answered by the appellate courts and possibly by remedial legislation. Since the Fund does not anticipate payment of substantial numbers of claims for 2 to 3 years, the urgency is not as great as has been argued. Notwithstanding, nonresolution of the funding questions both as to mandatory participation and use of the general fund of the state could be catastrophic since the funding projections of the Department of Insurance have been founded upon an assumption of mandatory participation of all health care providers.

## II. JOINT UNDERWRITING ASSOCIATION

Accompanying the passage of the Medical Malpractice Insurance and Claims Act was An Act to Establish a Medical Malpractice Liability Joint Underwriting Association[86] [hereinafter cited as Underwriting Act]. The purpose of the Underwriting Act is to authorize the Commissioner of Insurance to compel prescribed Kentucky insurers to become members of a joint underwriting association, and require that the association provide primary malpractice insurance coverage when it has been determined that the coverage is not available in the voluntary market.[87] As a condition precedent to transacting business in the state, every workmen's compensation, general liability, automobile liability, commercial multi-peril, and

[84] *Id.* at 10 of Brief for Defendant McGuffey.

[85] *Id.* at 21 of Brief for Defendant McGuffey. The constitutional attacks on this provision of the Act were numerous. Based upon sections 3, 49, 50, 58, 171, and 177 of the Kentucky Constitution, the arguments opposing the provision are well considered. To determine that the questioned provision of the Act is constitutional would apparently require more liberal interpretation of the cited sections of the Kentucky Constitution.

[86] KRS § 304.40 (1976).

[87] KRS § 304.40-030(1), (2).

health insurer must become a member of the association.[88]

Upon a determination by the Commissioner of Insurance that medical malpractice insurance cannot be made available in the voluntary market for physicians, hospitals, or all other licensed health care providers, he is required to implement the operation of the Joint Underwriting Association.[89] The association is empowered as follows:

> (a) to issue, or to cause to be issued, policies of insurance to applicants, including incidental coverages and subject to limitations as specified in the plan of operation, but not to exceed one hundred thousand dollars ($100,000) for each claimant under one (1) policy and one million dollars ($1,000,000) for all claimants under one (1) policy in any one (1) year;
> (b) to underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform those functions;
> (c) to assume reinsurance from its members;
> (d) to cede reinsurance; and
> (e) to negotiate and obtain in the voluntary market medical malpractice insurance for any health care provider to whom the association has issued or caused to be issued a policy of medical malpractice insurance with the foregoing limits.[90]

After implementation of the association, the health care provider is entitled to apply to the association for malpractice insurance,[91] or he may procure that coverage from the private market.[92]

While the Underwriting Act describes in detail the circumstances of its implementation,[93] the membership of the association,[94] the duties of the association,[95] the manner of rating of coverage,[96] the method of funding,[97] the management organiza-

[88] KRS § 304.40-030(1).
[89] KRS § 304.40-030(2).
[90] KRS § 304.40-040.
[91] KRS § 304.40-070.
[92] KRS § 304.40-030(2).
[93] KRS § 304.40-030(1)-(2).
[94] KRS § 304.40-030(1).
[95] KRS §§ 304.40-030(3), (4), -040.
[96] KRS §§ 304.40-050(4),(5) and (6), -080.
[97] KRS §§ 304.40-050, -060.

tion,[98] and the duration of the association,[99] it must be anticipated that the Underwriting Act will experience severe constitutional scrutiny. At this writing no challenge to the constitutionality of the Underwriting Act is known to have been filed. Nevertheless enactments of similar purpose elsewhere have been declared to be unconstitutional as an arbitrary interference with private business.[100]

## III. DECISIONS OF THE COURT

Although several cases involving issues relevant to medical malpractice were decided by the Kentucky Supreme Court during the past survey year, most fell within established legal standards and were passed upon by the Court without departure from prior case law. However, two cases received significant treatment by the Court, one involving a case of first impression in this jurisdiction, and the other resulting in an important departure from prior case law.

### A. *McMichael v. American Red Cross*

*McMichael v. American Red Cross*[101] is a case of first impression in Kentucky involving liability of the supplier of blood which may carry impurities and diseases resulting in injury to the recipient. In *McMichael* the Kentucky Supreme Court was confronted with the issues of whether the transfer of donor blood for a service fee was a "sale" within the meaning of the Uniform Commercial Code,[102] whether the appellee was a "seller" within the meaning of the Restatement (Second) of Torts,[103] and whether donor blood containing serum hepatitis virus was unavoidably unsafe within the meaning of the Restatement (Second) of Torts.[104]

McMichael had been hospitalized for severe burns, and during that time he had received whole blood plasma from five

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[98] KRS § 304.40-090.

[99] KRS § 304.40-030(2).

[100] Hartford Accident & Indemn. Co. v. Ingram, 226 S.E.2d 498, 507 (N.C. 1976).

[101] 532 S.W.2d 7 (Ky. 1975).

[102] KRS §§ 355.2-106, -314 and -315.

[103] RESTATEMENT (SECOND) OF TORTS § 402A (1965).

[104] *Id.* § 402A (comment *k*).

separate donors. The blood had been furnished to the hospital by the American Red Cross in a sterile condition for a service charge of $19.95 per unit. The Red Cross had utilized the "best available manner" to screen the donors for the prevention of possible contamination within the donor's blood. Nevertheless, 47 days later, within the normal incubation period for serum hepatitis, McMichael was diagnosed as having contracted that disease.[105]

A review of analogous foreign cases reveals that courts rarely recognize a recovery on the theories of implied warranty or strict liability. The rejection of these two theories of recovery is based on the theory that the "service" aspect predominates over the "sale" aspect in blood transfusion cases. In addition, the cost of the blood is viewed as merely an incidental feature of the services rendered and not indicative of a sale.[106] In support of his argument on the issues of whether the transfer of blood was a sale and whether the Red Cross was a seller, the appellee, American Red Cross, placed reliance upon this weight of authority, as well as on KRS § 139.125.[107] That statute provides in part that "the procurement, processing, distribution, or use of whole blood . . . is declared not to be a sale."[108] However, the Court did not consider it necessary to consider either of these issues. The Court based its decision solely on the remaining issue, and concluded that the blood given to McMichael was unavoidably unsafe under Section 402A of the Restatement (Second) of Torts. The Court ruled:

> We do not find it necessary to discuss the applicability or constitutionality of the statute, or the questions of whether, without regard to the statute, the transfer of donor blood by Red Cross to a hospital for a service fee is a *sale* under the Uniform Commercial Code, KRS 355.2-314 and 355.2-315, so as to give rise to an implied warranty, and whether Red Cross

[105] McMichael v. American Red Cross, 532 S.W.2d 7 (Ky. 1975).

[106] *See* Whitehurst v. American Nat. Red Cross, 402 P.2d 584 (Ariz. 1965); Hoder v. Sayet, 196 So. 2d 205 (Fla. 1967); Lovett v. Emory University, Inc., 156 S.E.2d 923 (Ga. App. 1967); Perlmutter v. Beth David Hospital, 123 N.E.2d 792 (N.Y. 1954); Hoffman v. Misericordia Hospital, 267 A.2d 867 (Pa. 1970); Gile v. Kennewick Public Hospital, 296 P.2d 662 (Wash. 1956); Koenig v. Milwaukee Blood Center, Inc., 127 N.W.2d 50 (Wis. 1964).

[107] McMichael v. American Red Cross, 532 S.W.2d at 7, 8, & 9 (Ky. 1975).

[108] KRS § 139.125.

> is a *seller* under Section 402A of the Restatement of Torts 2nd so as to be subject to strict tort liability. Our conclusion is that even if the statute be inapplicable or unconstitutional, and even if the transfer be deemed a sale and Red Cross a seller, the directed verdict in the instant case was proper because under the stipulated facts there were no methods available at the time in question by which hepatitis virus could effectively be excluded from blood or the presence of the virus determined. Therefore, the blood involved in the instant case, to the extent it may have contained hepatitis virus, was unavoidably unsafe as discussed in Comment (K) under Section 402A of the Restatement and for that reason it was not unreasonably dangerous within the terms of Section 402A and it did not fail to be fit within the terms of the warranties provided for in the Uniform Commercial Code, KRS 355.2-314 and 355.2-315.[109]

While the Court's decision is amply supported by existing case law, it is unfortunate that the Court decided the case upon this narrow ground. Clearly, future litigation on the issues of whether the furnishing of blood is a sale or service (which may also necessitate a constitutionality decision on KRS § 139.125), and whether the Red Cross is a seller within the meaning of the Restatement will arise in serum hepatitis[110] as well as other contaminated or "bad" blood cases.[111]

### B. *Laws v. Harter*

The decision of the Supreme Court of Kentucky in *Laws v. Harter*[112] is more than another review of the typical sponge case. It removes any notion that liability is an issue in analogous cases and discloses that the Court is willing to declare certain actions by physicians to be negligent without regard to evidence of acceptable medical standards.

In that case the plaintiff, Laws, underwent a surgical procedure which was performed by the defendant, Harter. During

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[109] McMichael v. American Red Cross, 532 S.W.2d at 9 (Ky. 1975).

[110] *See* Boland, *Strict Liability in Tort for Transferring Contaminated Blood,* 23 ARK. L. REV. 236, 241-42 (1969), where it is asserted that a method of prediction in serum hepatitis cases may exist.

[111] A detailed discussion of this as well as other problems posed by McMichael can be found in Ausness, *Kentucky Law Survey-Torts, supra* p. 301.

[112] 534 S.W.2d 449 (Ky. 1975).

the course of the surgery, and before an incision into the diaphragm was closed, a sponge count was completed and reported as accurate.[113] The incision in the diaphragm was then sutured and a second count was completed prior to the closure of the incision in the chest wall. At this point a sponge was found to be missing.[114] The sponge contained an opague material and x-rays were secured for the purpose of locating the sponge. The sponge was not found and the patient was closed for medical considerations.[115] A sponge was thereafter located by x-ray and surgically removed.[116]

At trial the physician obtained a directed verdict after submitting evidence that all possible care had been exercised. The patient appealed the decision[117] and again the physician asserted that the record of the case contained no evidence of negligence.

> This included looking in the "kick bucket"; looking on the floor; looking on the back table; looking on the bottoms of the operating team's shoe covers; and even looking outside the operating room itself on the off-chance that it might have been carried out on someone's clothing. When that failed, the next proper and customary step was followed and that step was the use of an x-ray machine in the operating room itself with the patient still open. The three experts involved—the radiologist, Dr. Harter with his many years of experience, and Dr. Bowers with his many years of experience, were unable to locate the sponge by that usual method. When that proper method also failed—as had the all hands search—Dr. Harter and Dr. Bowers took the next step which is also customary and usual of getting yet another x-ray. Still no success![118]

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[113] Generally, at the beginning of a surgical operation the number of sponges marked with a radiopaque filament are counted and the number is audibly declared and recorded by the scrub nurse and circulating nurse. No sponges are removed from the operating room during surgery and continual care is maintained to account for the presence of each sponge. Should a sponge be cut by a surgeon he deliberately presents the pieces to the nurse in order to keep them in one place. Before the closure of a large wound the circulating nurse counts the used sponges and the scrub nurse counts the unused sponges. The total must equal the number given to the scrub nurse at the beginning of the surgery. Annot., 16 AM. JUR. *Proof of Facts* 155, 171-72 (1965).

[114] 534 S.W.2d at 450 (Ky. 1975).

[115] *Id.*

[116] *Id.*

[117] *Id.*

[118] Brief for Appellee Harter at 13-14, Laws v. Harter, 534 S.W.2d 449 (Ky. 1975).

In its decision the Supreme Court of Kentucky conceded that the physician may have exercised the "highest degree of skill known to the medical profession" in his attempt to locate the missing sponge.[119] Nevertheless the Court concluded that the physician was *negligent as a matter of law* in failing to properly account for the sponge.[120]

This represents a departure from past decisions of the Court since prior to *Laws* the Court has always held the issue of the physician's negligence to be for the jury's determination. In *Butts v. Watts*[121] an issue was submitted as to whether expert opinion was required to establish that a dentist was negligent in failing to remove a portion of a broken tooth from a patient. The Court commented that this was similar to leaving a foreign object in the body of a surgical patient wherein the Court *had previously held the physician negligent per se.*[122] However, a review of the Kentucky cases relied upon by the Court for that conclusion reveals that it is erroneous. In the first, *Samuels v. Willis*[123] a physician was charged with negligently leaving a sponge in a surgical incision.[124] In affirming a jury verdict the Court said that it was for the jury to determine whether the physician exercised the requisite degree of care.[125] In the second case cited by the Court, *Barnett's Administrator v. Brand,*[126] the Court not only concluded that the identical issue was for the jury but also prescribed a jury instruction on behalf of the physician.[127] That instruction provided a defense to the physician if a delay in closure of the incision would have endangered the safety of the patient.[128] Thus *Laws* does repre-

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[119] 534 S.W.2d at 451 (Ky. 1975).

[120] *Id.*

[121] 290 S.W.2d 777 (Ky. 1956).

[122] *Id.* at 780.

[123] 118 S.W. 339 (Ky. 1909).

[124] *Id.* at 340.

[125] *Id.* at 342.

[126] 177 S.W. 461 (Ky. 1915).

[127] *Id.* at 464.

[128] *Id.*

We also conclude that on another trial the court, in lieu of instruction No. 6, should tell the jury, in substance, that if they believe from the evidence that the defendant believed, and had reasonable grounds to believe, that the condition of the decedent was such that further delay in exploring for pads and sponges, or in closing the operation, would endanger her safety,

sent a significant departure from prior decisions.[129]

While *Laws* lacks general support in other jurisdictions,[130] Louisiana recently adopted a similar rule in *Guilbeau v. St. Paul Fire and Marine Insurance Co.*[131] A surgeon, who had closed a surgical patient prior to removal of a laparotomy pad, was held to be negligent per se in that case.[132] In a dissenting opinion and a dissent to a denial of rehearing it was argued that the surgeon properly relied upon the sponge count as accurate which conformed to the best medical standards; that to have disregarded the sponge count and probed for the unknown pad would have endangered the patient by spreading disease to healthy tissue; and that the majority decision was an adoption of a "strict liability" approach.[133]

> Under the rule of this case, even the most extraordinary degree of skill and caution, even the most unusual surgical procedures performed under adverse circumstances, will not serve to exculpate the surgeon.
>
> . . . .
>
> . . . There is no precedent in our law for applying such a strict standard of liability to a surgeon. It is wholly inappropriate since the essence of his work is skill and caution, not a mechanical disassembly and reassembly of components.[134]

Arguably, the above comments are applicable to *Laws*.

In *Laws* the Court ruled that on retrial the jury was to be instructed to find for the plaintiff should it determine that another surgical procedure was required to remove the sponge. The Court thus removes from jury consideration all relevant testimony regarding the nature and the circumstances of the surgery, whether ordinary or extraordinary. The excluded testimony includes evidence relating to both the proper medical

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the defendant was not negligent in then leaving the pad or sponge in the decedent's abdomen, and they cannot find for the plaintiff on that ground.

[129] *See also* Hazard Hospital Co. v. Combs Adm'r, 92 S.W.2d 35 (Ky. 1936); Jett v. Linville, 259 S.W. 43 (Ky. 1924).

[130] *See* Burke v. Washington Hospital Center, 475 F.2d 364 (D.D.C. 1973); Robinson v. St. Johns Medical Center, 508 S.W.2d 7 (Mo. App. 1974); Easter v. Hancock, 346 A.2d 323 (Pa. Super. 1975); Annot., 10 A.L.R.3d 9 (1966).

[131] 325 So. 2d 395 (La. 1975).

[132] *Id.* at 398.

[133] *Id.* at 398-400.

[134] *Id.* at 400.

standards and the necessity of closure of an incision for medical considerations.

The Court has previously established evidentiary exceptions to the rule that expert medical testimony is required to establish a breach of care by a physician.[135] A physician owes his patient that degree of care and skill which is expected of a reasonably competent practitioner in the same speciality, acting in similar circumstances[136] and expert opinion is required to establish a breach of this duty if the negligence is not so apparent that laymen with general knowledge would recognize it.[137] In determining that Harter was negligent as a matter of law the Court moved beyond the evidentiary exception to disregard expert medical testimony relevant to the issue of breach of care. Certainly it cannot be argued that the court should not retain the power to determine that the usual practices of the medical profession, or any profession, fail to meet the standard of reasonable care—to hold the defendant liable notwithstanding the fact that his actions were in accord with standard practice. To prohibit the court from this would diminish the deterrent effect of negligence law and result in extreme unfairness in particular cases. However, it would be overstepping that power for the Court to declare certain acts negligent as a matter of law where the usual practices of that profession are not unreasonable in themselves in light of circumstances peculiar to the specific practice.

At this time the impact of *Laws v. Harter* upon decisions by the Kentucky trial courts and Kentucky physicians is of primary concern. If *Laws* is interpreted by the trial court as limiting issues and evidence to the question of damages, then indeed the physician will be subjected to "strict liability" in foreign object cases without regard to the medical situation or standard practice. The potential inequities to the physician are apparent. More important, however, is the potential impact of *Laws* upon medical decision-making. As described in *Guilbeau,* there is danger that the search for foreign objects will be evaluated above the higher priority of the patient's health. It is suggested that the Court reexamine its position in *Laws* in view of its potential effects.

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[135] Johnson v. Vaughn, 370 S.W.2d 591, 596 (Ky. 1963).
[136] Blair v. Eblen, 461 S.W.2d 591, 596 (Ky. 1963).
[137] *Id.*