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Commonwealth Of Kentucky

Court Of Appeals

NO. 1999-CA-002223-MR

PINEVILLE COMMUNITY HOSPITAL ASSOCIATION, INC. APPELLANT

v.

APPEAL FROM BELL CIRCUIT COURT
HONORABLE FARMER H. HELTON, JUDGE
ACTION NO. 97-CI-00091

ALICE COX AND
LAWRENCE K. BUTCHER, M.D. APPELLEES

AND: NO. 1999-CA-002226-MR

LAWRENCE K. BUTCHER, M.D. APPELLANT

v.

APPEAL FROM BELL CIRCUIT COURT
HONORABLE FARMER H. HELTON, JUDGE
ACTION NO. 97-CI-00091

ALICE COX AND
PINEVILLE COMMUNITY HOSPITAL ASSOCIATION, INC. APPELLEES

OPINION
AFFIRMING

** ** ** ** **

BEFORE: GUDGEL, CHIEF JUDGE; DYCHE AND MILLER, JUDGES.

MILLER, JUDGE: Lawrence K. Butcher, M.D. brings Appeal No. 1999-CA-002226-MR, and Pineville Community Hospital Association, Inc. brings Appeal No. 1999-CA-002223-MR from a July 16, 1999, judgment of the Bell Circuit Court. We affirm.

In April 1985, Alice Cox was examined by Dr. Lawrence K. Butcher in the emergency room of Pineville Community Hospital. Dr. Butcher diagnosed Cox as having an "ectopic pregnancy"[1] necessitating immediate emergency surgery. During the course of surgery, Dr. Butcher used "laparatomy packs" or "sponges." According to testimony of hospital operative staff and/or of Dr. Butcher, the number of packs had been counted before surgery and then twice following completion of surgery. Both Dr. Butcher and the hospital's operative staff testified that there was no discrepancy between the number of packs counted before surgery and following surgery.

Some six years later, on February 15, 1991, Cox fell over a coffee table injuring her "tailbone" and went to the emergency room at Middlesboro Appalachian Regional Hospital. An x-ray was performed upon Cox and revealed a "foreign object" in her abdomen. An emergency room physician recommended additional tests, but Cox refused. The physician instructed Cox to follow up with her family physician. In relation to these events, Cox testified as follows:

Q You said in 1991 you fell?

A Uh-huh (affirmative).

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[1] A pregnancy occurring elsewhere than in the cavity of the uterus. STEDMAN'S MEDICAL DICTIONARY 440 (4th ed. 1976).

. . . .

> And I thought I broke my hip or something, so I went to the hospital the next morning and Dr. Cabuay -- it was a foreign doctor that saw me and he said, lady, I think you have something in your pocket. He said there's something inside you or something. And I thought well, you're crazy, there's nothing -- he made -- he made me think there was some kind of something in me beside something I didn't know. And I went to -- I panicked. I got scared and I ran out of the hospital. (Plaintiff's deposition pp. 15-16.)

. . . .

A He sent me for an x-ray.

Q Okay, and what did those x-rays show; do you know?

A. He said it looked like something in -- inside of me, like an object or something. He didn't know what it was. And I took it to be a tumor or cancer or something like that. And I didn't want no more operations, because I don't like doctors that good. (Plaintiff's deposition p. 17.)

Because of declining health, Cox underwent exploratory surgery on June 3, 1996. During this procedure, an encapsulated sponge was found in Cox's abdomen.

On March 6, 1997, Cox filed an action in the Bell Circuit Court against Butcher and Pineville Community Hospital. Therein, she alleged that Butcher and Pineville Community Hospital were negligent for injuries she sustained when a surgical sponge, also referred to as a laparatomy pack, was left in her abdomen during the April 1985 surgery. Pursuant to a jury verdict, the trial court entered judgment in favor of Cox in the amount of $417,500.00, of which twenty-five percent was allocated

against Butcher and seventy-five percent against Pineville Community Hospital. The award included $300,000.00 for past pain and suffering, $100,000.00 for future pain and suffering, and $17,500.00 for medical expenses. In an August 18, 1999, order, the trial court reduced the medical award to $8,218.41. This appeal follows.

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Dr. Butcher contends the trial court committed error by overruling his motion for summary judgment upon statute of limitation grounds. Summary judgment is proper where there exists no material issue of fact and movant is entitled to judgment as a matter of law. Ky. R. Civ. P. (CR) 56; Steelvest, Inc. v. Scansteel Service Center, Inc., Ky., 807 S.W.2d 476 (1991).

The applicable statute of limitations is found in Kentucky Revised Statutes (KRS) 413.140, which states, in relevant part, as follows:

> (1) The following actions shall be commenced within one (1) year after the cause of action accrued:
>
> . . . .
>
> (e) An action against a physician, surgeon, dentist or hospital licensed pursuant to KRS Chapter 216 for negligence or malpractice.
>
> . . . .
>
> (2) . . . the cause of action shall be deemed to accrue at the time the injury is first discovered or in the exercise of reasonable care should have been discovered . . . .

Under Kentucky law, it is well established that:

> The statute begins to run on the date of the discovery of the injury, or from the date it should, in the exercise of ordinary care and diligence, have been discovered. [Citation omitted.] This rule entails knowledge that a plaintiff has a basis for a claim before the statute of limitations begins to run.

Wiseman v. Alliant Hospitals, Inc., Ky., ____ S.W.3d ____ (rendered November 22, 2000)(quoting Hackworth v. Hart, Ky., 474 S.W.2d 377, 379 (1971)). In order to trigger the statute of limitations under the discovery rule, the plaintiff must know: (1) she has been wronged, and (2) by whom the wrong has been committed. Wiseman, ____ S.W.3d ____ (citing Drake v. B.F. Goodrich Company, 782 F.2d 638 (6th Cir. 1986)), Hazel v. General Motors Corp., 863 F. Supp. 435 (W.D. of Ky. 1994). Indeed, it is necessary the plaintiff possess knowledge of the injury and the causal relationship to the malpractice. See Wiseman, ____ S.W.3d _____.

Dr. Butcher argues that the statute of limitations was triggered in February 1991 when the x-ray revealed a foreign body in Cox's abdomen. Dr. Butcher maintains that at the very least a question of fact existed upon whether a reasonable person should have known of the "injury" in February 1991. We disagree.

Under the circumstances of the instant case, we do not believe that the February 1991 x-ray was sufficient to trigger the statute of limitations. The object upon the x-ray could have been a variety of diseases and/or conditions. It also could have been the product of a faulty x-ray. As stated by the circuit court in its January 26, 1999, order:

> Not even the doctors knew what was in her body until the surgery. This area between

> the thorax and pelvis is an area susceptible of multiple conditions.

In sum, we do not think the x-ray was sufficient to put Cox on notice of her injury -- the encapsulated sponge.

Additionally, we simply do not believe an issue of fact existed. It is undisputed that the x-ray in no way revealed a causal relationship between the foreign object and the 1985 surgery. As a matter of law, we do not think the **February 1991 x-ray would put a reasonable person upon notice that a sponge was left in the abdomen from a 1985 surgery**. Hence, we hold the trial court did not commit error by denying Dr. Butcher's motion for summary judgment upon statute of limitation grounds. We think that Cox's action was timely filed as a matter of law.

Dr. Butcher also argues the trial court committed error by granting Cox's motion for partial summary judgment upon the issue of liability. The trial court entered summary judgment concluding that Dr. Butcher was negligent *per se*[2] relying upon Laws v. Harter, Ky., 534 S.W.2d 449 (1975).

In Laws, appellant underwent a type of thoracic surgery known as the Thal procedure. In the procedure, an incision was made in the chest wall to gain entry to appellant's **chest cavity** and then an additional incision was made through the diaphragm to access the **abdominal cavity**. Before the incision in the diaphragm was closed, a sponge count was made and reported accurate. The incision in the diaphragm was then closed. A

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[2]We use the terms "negligent *per se*" and "negligent as a matter of law" interchangeably.

second sponge count was made prior to closing the incision through the chest wall, and the count revealed that one sponge was missing. A search for the sponge was made in the chest cavity to no avail. The surgeon ordered x-rays for the purpose of locating the sponge; however, the sponge was not located upon x-ray. The surgeon then decided that it would be better to close and later explore for the missing sponge. Subsequent x-rays of appellant revealed the sponge in the **abdomen**. An additional operation successfully removed the sponge.

Appellant asserted that it is negligence *per se* for a surgeon to leave a sponge inside of a patient. Upon this issue, the Court opined:

> We conclude that appellee . . . was negligent as a matter of law. It may be true, as he claims, that when it was discovered that a sponge was missing, he exercised to the highest degree all of the skills known to the medical profession in his attempt to locate the missing sponge, and having failed to locate it, the condition of the patient at that time may have been such that any reasonably prudent surgeon would have closed the patient.
>
> However exemplary the care given to appellant after discovering that a sponge was missing, **the fact remains that when the incision through the diaphragm was closed a sponge was left in the abdomen. The sponge count at that time failed to show any sponge missing but in truth one of the sponges was missing and the count was inaccurate. The failure to correctly account for the sponges under the circumstances constituted negligence as a matter of law**. (Emphasis added.)

Id. at 450, 451.

Dr. Butcher disagrees with the trial court's reliance upon Laws and points to a recent case of this Court -- Chalothorn v. Meade, Ky. App., 15 S.W.3d 391 (1999). In Chalothorn, appellee underwent a cesarean delivery of her baby. An initial count of sponges indicated that one was missing; however, the circulating nurse called the nursery and was informed that a sponge had accompanied the baby from the operating room to the nursery. The nurse then informed the doctor the count was correct. He closed the incision and finished the operation. At a later time, the hospital staff determined the sponge in the nursery was not a surgical sponge. The doctor then arranged for removal of the sponge which was accomplished by laparoscopy and without complications. The issue presented in Chalothorn was whether the physician was negligent as a matter of law for leaving a sponge inside of appellee. The Chalothorn Court determined the physician was not and held Laws distinguishable:

> The *Laws* case is distinguishable from the present case in that the physician in *Laws* was aware that a sponge was missing when he decided, for medical reasons, to go ahead and close the incision. He apparently felt that it was better to go ahead and close the patient and try to find the sponge later (either inside or outside of the patient) than to leave the patient open for an extended period of time. The Court of Appeals held that closing the patient with a missing sponge was negligence *per se*.
>
> In the present case, the sponge count was reported to Dr. Chalothorn as correct. There was no decision to close . . . [appellee's] incision while a sponge was unaccounted for.

Chalothorn, 15 S.W.3d 391, 393.

Relying upon Chalothorn, Dr. Butcher argues that he was not negligent *per se* because the sponge count was reported to him as correct as was the case in Chalothorn; thus, he maintains the trial court erred by entering partial summary judgment.

We do not now interpret the Laws decision as it was interpreted in Chalothorn.[3] In Laws, the sponge count was reported to the surgeon **as correct when the diaphragm was closed -- locking the sponge in the abdominal cavity**. We view this fact as pivotal. As previously stated, the incision in the diaphragm was made so that the surgeon could access the abdominal cavity. The sponge was left in the abdominal cavity. The Court concluded that failure to correctly account for sponges before closing the diaphragm constituted negligence *per se*. As specifically held by the Court:

> [T]he fact remains that when the incision through the diaphragm was closed a sponge was left in the abdomen. **The sponge count at that time failed to show any sponge missing but in truth one of the sponges was missing and the count was inaccurate. The failure to correctly account for the sponges under the circumstances constituted negligence as a matter of law**. (Emphasis added.)

Laws, 534 S.W.2d 449, 450-451.

Unlike Chalothorn, we do not believe Laws stood for the proposition that a physician is negligent *per se* only when he decides to close a patient with knowledge that a sponge is missing. As a matter of fact, we are of the opinion Laws stands

[3]The Court of Appeals is bound to follow Supreme Court precedent. Rule of the Supreme Court (SCR) 1.030(8)(a).

for the exact opposite proposition. In Laws, the Court explained that the surgeon exercised the highest degree of skills known to the medical profession in his attempt to locate the missing sponge, and having failed to locate it, acted as any reasonably prudent surgeon in closing the patient. The surgeon in Laws was not held negligent *per se* because of closing the patient's chest cavity knowing a sponge was missing, **but rather for closing the diaphragm based upon an inaccurate sponge count.** In sum, we interpret Laws as holding that a sponge left inside a patient's body because of the failure to correctly account for sponges during an operation constitutes negligence as a matter of law. As such, we are of the opinion that the circuit court did not commit error by entering partial summary judgment finding Dr. Butcher negligent *per se* for leaving a sponge in Cox during the 1985 operation.

Dr. Butcher also contends the trial court committed error by failing to give a comparative negligence or apportionment instruction permitting the jury to consider Cox's liability. In this Commonwealth, the trial court has a duty to instruct upon any theory of law supported by the evidence introduced at trial. Risen v. Pierce, Ky., 807 S.W.2d 945 (1991). In the case at hand, we do not believe that Dr. Butcher was entitled to a comparative negligence or apportionment instruction. Dr. Butcher proposed such instructions were warranted because Cox had a duty to use ordinary care and reasonable diligence to secure appropriate treatment for her injury. See Deutsch v. Shein, Ky., 597 S.W.2d 141 (1980).

Moreover, Dr. Butcher argues Kentucky law imposes a duty upon Cox to mitigate her damages. See Blair v. Eblen, Ky., 461 S.W.2d 370 (1970). We agree with Dr. Butcher that such is the law in this Commonwealth; however, Dr. Butcher overlooks the fact that Cox was unaware of her injury until 1996. We do not believe that Cox had a duty to seek appropriate treatment of an injury or to mitigate damages until she knew of the injury. To hold otherwise simply defies common sense.

Moreover, the law in relation to neglect injuries does not preclude recovery for enhanced damages so long as the injured person acts reasonably. See City of Covington v. Keal, 280 Ky. 237, 133 S.W.2d 49 (1939). The circumstances under which Cox found herself by reason of Dr. Butcher's negligence do not lead us to conclude that her response was unreasonable. As such, we reject Dr. Butcher's argument.

Dr. Butcher further maintains the circuit court committed error by failing to direct a verdict or sustain a motion for new trial upon the grounds that the negligence of the hospital's nursing staff was a superseding or intervening cause. We disagree. In Barnett's Adm'r v. Brand, 165 Ky. 616, 177 S.W. 461, 464 (1915), the Court stated:

> In performing an operation, it is the duty of a surgeon to exercise reasonable care and skill. The operation begins when the incision is made and ends when the opening has been closed in the proper way, after all the appliances necessary to a successful operation have been removed from the body. Throughout the operation the law imposes on the surgeon the duty of exercising such care and skill. The removal of the sponges or pads is a part of the operation, and an operation cannot be said to be concluded

> until such removal takes place. For this reason, it is generally held that a surgeon cannot relieve himself from liability for injury to a patient by leaving a sponge in the wound after the operation, by any custom or rule requiring the attending nurse to count the sponges used and removed, accompanied by the statement of the nurse that the sponges were all properly accounted for, and his reliance on such statement. (Emphasis added.)

See also City of Somerset v. Hart, 549 S.W.2d 814 (1977) (holding that operating room staff acts as servants of both of the surgeon and the hospital as a matter of law). Under Kentucky law, Dr. Butcher cannot escape liability for leaving a sponge in a patient by relying upon the operating room staff. Id.

Dr. Butcher also asserts the evidence did not support an instruction on future and past pain and suffering. The jury awarded Cox $300,000.00 for past pain and suffering and $100,000.00 for future pain and suffering. Cox testified that her health problems started in 1988. At that time, she experienced lack of energy and loss of weight. In 1995, her symptoms worsened. She testified to vomiting frequently, to feeling “real bad,” and to being unable to eat. She stated that most of the domestic chores were done by her daughter. We think this evidence sufficient to create a submissible jury issue upon damages for past pain and suffering. See Risen, 807 S.W.2d 945.

As to future pain and suffering, Cox offered the testimony of Dr. Meredith Evans. Dr. Evans testified that Cox might indeed experience problems in the future as a result of the surgery or adhesions resulting thereof. We believe this evidence

sufficient to present a submissible jury question of future pain and suffering. See Id.

Dr. Butcher further argues that the trial court committed error by allowing Cox to recover damages for pain and suffering when she did not disclose same in an answer to an interrogatory as provided by CR 8.01. In Fratzke v. Murphy, Ky., 12 S.W.3d 269 (1999), the Court held that failure to specify the amount of damage for pain and suffering in an answer to an interrogatory requesting disclosure of such unliquidated damage barred recovery of same at trial. We have searched the appellate record and have been unable to located the propounded interrogatory and/or Cox's answer to same. The parties disagree as to whether the propounded interrogatory specifically requested disclosure of damage for pain and suffering.

It is well established that the burden is upon appellant to include in the appellate record all that is necessary for appellate review. See Burberry v. Bridges, Ky., 427 S.W.2d 583 (1968), and Fanelli v. Commonwealth, Ky., 423 S.W.2d 255 (1968), *rev'd on other grounds*, Ky., 445 S.W.2d 126 (1969). The propounded interrogatory and answer are essential to our review. Without the documents properly admitted into the record, we are unable to examine the exact language of the propounded interrogatory and of the answer. As such, we summarily affirm the trial court upon this issue.

Dr. Cox contends that the trial court erred by allowing introduction of an enlarged photo of the encapsulated sponge removed from Cox's abdomen and by refusing to grant a mistrial

when appellee's counsel instructed the jury in closing arguments to send a message. We view these alleged errors, individually or cumulatively, as merely harmless. CR 61.01. We simply do not believe these alleged errors rise to the level of substantial prejudice requiring reversal of the judgment. See Hall v. Hamlin, Ky., 484 S.W.2d 853 (1972).

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Upon the grounds enunciated in Appeal No. 1999-CA-002226-MR, we likewise affirm Appeal No. 1999-CA-002223-MR.[4]

For the foregoing reasons, the judgment of the Bell Circuit Court is affirmed.

GUDGEL, CHIEF JUDGE, CONCURS.

DYCHE, JUDGE, CONCURS IN RESULT.

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[4]In its reply brief, Pineville Community Hospital attaches a proposed interrogatory and answer as "Exhibit 1" and "Exhibit 2." It does so to support the argument that Cox failed to comply with Ky. R. Civ. P. 8.01. The propounded interrogatory and answer was not found in the appellate record, and thus is not before this Court. It was, therefore, improper to include such "exhibits" in the reply brief. See Croley v. Alsip, Ky., 602 S.W.2d 418 (1980).