RENDERED: FEBRUARY 13, 2015; 10:00 A.M.
TO BE PUBLISHED

Commonwealth of Kentucky

Court of Appeals

NO. 2011-CA-002202-MR

WILBERT E. HORSLEY — APPELLANT

v.

APPEAL FROM JEFFERSON CIRCUIT COURT
HONORABLE FREDERIC COWAN, JUDGE
ACTION NO. 10-CI-002420

KENNETH R. SMITH, M.D.,
INDIVIDUALLY AND D/B/A
KS EYEWORKS — APPELLEES

OPINION
AFFIRMING

** ** ** ** **

BEFORE: ACREE, CHIEF JUDGE; DIXON AND VANMETER, JUDGES.

ACREE, CHIEF JUDGE: Appellant, Wilbert Horsley, appeals from a judgment of the Jefferson Circuit Court entered after a jury verdict in favor of Appellees, Dr. Kenneth Smith and KS EyeWorks. For the reasons set forth herein, we affirm.

FACTS AND PROCEDURE

Dr. Smith, a Louisville ophthalmologist and owner of KS EyeWorks, specializes in cataract and refractive eye surgery. Dr. Smith first consulted Horsley in 2006 regarding Horsley's diminishing eyesight, later becoming his treating physician. Dr. Smith determined that Horsley suffered from cataracts. He initially prescribed eyeglasses as a conservative course of treatment. Eventually, Horsley's eyesight deteriorated so that it rendered corrective lenses ineffective. Dr. Smith again consulted Horsley and scheduled him for cataract surgery.

As part of the work-up for surgery, Dr. Smith explained the procedure and its attendant risks to Horsley. The procedure included administering a local anesthetic to the eye by injection – an injection which risked hitting one of the eye's many blood vessels. After explaining this, Dr. Smith left Horsley to consider whether to proceed with surgery and provided him a consent document to be signed and returned. The consent document included this statement: "The ophthalmologist or the anesthesiologist/nurse anesthetist will make your eye numb with either drops or an injection (local anesthesia)." The document also listed a host of risks related to the procedure, including "total loss of vision, or even loss of the eye . . . ."

After weighing his options, Horsley decided to have the surgery and signed and returned the consent form to the doctor.

Dr. Smith performed the first surgery on Horsley's right eye. As was his practice, Dr. Smith used a needle to administer the anesthetic. The surgery was

successful and Dr. Smith scheduled a second operation for Horsley's left eye about a month later.

As with the right eye surgery, Dr. Smith began the procedure on the left eye by administering an anesthetic injection. This time, there were complications when the needle ruptured a blood vessel in Horsley's left eye resulting in blindness in that eye.

Horsley filed a medical malpractice action in Jefferson Circuit Court against Dr. Smith, individually, and against the doctor's practice, KS EyeWorks (Dr. Smith). The stated claim was one count of common law medical negligence and included allegations that:

> 4. [I]t was the duty of [Dr. Smith] to exercise that degree of learning, skill, ability, care, attention, diligence, prudence, common sense and vigilance ordinarily possessed by physicians, surgeons and ophthalmologists, practicing under the same or similar circumstances and to obtain [Horsley's] informed consent regarding the surgical procedures to be performed . . . .
>
> 5. [Dr. Smith was] negligent in the care and treatment of [Horsley] in that [he] failed to use the same degree of skill, diligence and care as is possessed by prudent, skillful, careful and knowledgeable physicians, surgeons and ophthalmologists under the same or similar circumstances and otherwise deviated from the standard of care applicable thereto.
>
> 6. [Dr. Smith] failed to obtain [Horsley's] informed consent regarding the surgical procedures performed upon [Horsley].
>
> 7. As a direct and proximate result of [Dr. Smith's] negligence, deviations from the standard of care and lack

> of informed consent, [Horsley] sustained severe, permanent and disabling injuries . . . .

We note that Horsley thus properly stated the elements of his claim. Paragraph 4 sets out the single legal duty Dr. Smith owed. Ultimately, this same language, or its equivalent, was used as the jury instruction on duty. Then, in paragraphs 5 and 6, he alleged two different ways Dr. Smith breached that single duty – negligence performing the operation itself, and failure to obtain informed consent. Paragraph 7 covers causation, and in a subsequent paragraph he claimed damages.

The case culminated in a three-day jury trial. Horsley argued both that Dr. Smith negligently administered the anesthesia, and that he failed to adequately explain the anesthesia could have been administered by using numbing drops instead of injection. Horsley claimed that had Dr. Smith made him aware of these alternative methods, his decision to undergo surgery may have been different.

On cross-examination, Horsley's counsel presented Dr. Smith with a page from the American Medical Association (AMA) website. Dr. Smith agreed with the statement there that, depending on the situation, it is appropriate to inform a patient of alternatives to the proposed course of treatment and associated risks.

Dr. Smith admitted further that although there are several ways to administer anesthesia before cataract surgery, his standard practice was to perform an injection. While Dr. Smith recalled discussing with Horsley the different ways of

administering anesthesia, he conceded that he did not give Horsley the option of selecting his choice of anesthesia.

At the close of evidence, Horsley moved for a directed verdict on the issue of informed consent. The trial court denied the motion, and proceeded to address arguments about jury instructions.

Horsley first tendered a general instruction regarding a physician's duty of care. The instruction stated, in pertinent part: "it was the duty of [Dr. Smith] to exercise that degree of care and skill which an ordinarily careful, skillful, knowledgeable and prudent physician specializing in Ophthalmology would use under circumstances like or similar to those shown in this case." (Plaintiff's Tendered Instruction No. 1).[1]

Horsley also tendered a second instruction which he attributed to Palmore, Kentucky Instructions to Juries, Fifth Ed., § 23.10. The instruction stated: "With respect to disclosing to [Horsley] the risks of the surgical operation he proposed to perform on him, it was the duty of [Dr. Smith] to exercise the degree of care and skill expected of a reasonable competent practitioner specializing in ophthalmology and acting under similar circumstances." (Plaintiff's Tendered Instruction No. 2). Except for the introductory clause regarding disclosing risks,

[1] This instruction is incorrectly attributed to "Palmore, Kentucky Instructions to Juries, Fifth Ed., § 23.12 *et seq*." Section 23.12 is a model instruction for "Wrongful Death of Fetus; Issue of Viability." The language that most closely resembles Horsley's instruction is found in § 23.01, entitled, "Liability of Physician or Surgeon to Patient; Standard of Care." This misidentification has no effect on our review.

the two proposed instructions are substantively identical. However, Horsley did not offer this instruction as an alternative, but in addition to the first instruction.

Largely consistent with Horsley's first instruction and paragraph 4 of his complaint, the circuit court instructed the jury as follows:

> It was the duty of Dr. Kenneth Smith in treating Wilbert Horsley to exercise the degree of care and skill of a reasonably competent ophthalmologist acting under similar circumstances. If you are satisfied from the evidence that Dr. Smith failed to comply with this duty, and further satisfied that such failure was a substantial factor in causing the injuries complained of by Wilbert E. Horsley, then you will find Dr. Smith at fault.

The jury found for Dr. Smith. Horsley's motions for a new trial or judgment notwithstanding the verdict were denied, and the trial court entered judgment in accordance with the verdict. Horsley now brings this appeal.

ANALYSIS

Horsley presents four arguments, each with its own standard of review. Those arguments are: (1) the trial court erred by failing to instruct separately on Smith's duty to obtain Horsley's informed consent; (2) the trial court erred by excluding an exhibit Horsley tendered; (3) the trial court erred by overruling Horsley's directed verdict motion; and (4) the trial court erred by failing to strike Smith's Answer to the Complaint. We address them in order.

The trial court did not err in instructing the jury.

Alleged errors regarding jury instructions are considered questions of law that we examine under a *de novo* standard of review. *Reece v. Dixie Warehouse &*

Cartage Co., 188 S.W.3d 440, 449 (Ky. App. 2006). We have considered the arguments, examined the record and the law, and conclude that the trial court properly instructed the jury on Horsley's claim of medical negligence.

Horsley believes it was improper for the circuit court to instruct the jury with a single instruction that Dr. Smith owed him the duty to exercise the degree of care and skill of a reasonably competent ophthalmologist acting under similar circumstances. He claims the jury should have been instructed separately and additionally that Dr. Smith owed him the duty to disclose the risks of the procedure, the duty to alert him to alternate anesthesia methods, and then the duty to obtain his consent to surgery. We disagree.

We conclude that informing the patient of risks and options and obtaining consent to surgery are just a few of the many medical responsibilities expected of physicians who must abide by a standard of care defined by the medical profession itself,[2] the failure of which constitutes the breach of a legal duty. All such medical responsibilities can be adequately addressed in a single duty instruction. They always have been and they were in this case.

The law is clear as to the legal duty owed by a physician to his patient: "A physician has the duty to use the degree of care and skill expected of a competent practitioner of the same class and under similar circumstances." *Hyman &*

[2] "[T]he law has . . . continued to afford the medical profession and other learned professions a privilege which it has ordinarily refused to other groups . . . and that is the freedom to set their own legal standards of conduct. The policy justification implicitly advanced is the respect which the courts have had for the learning of a fellow profession accompanied by reluctance to overburden it 'with liability based on uneducated judgment.'" *Holton v. Pfingst*, 534 S.W.2d 786, 788 (Ky. 1975) (quoting W. Prosser, *Handbook of the Law of Torts*, 165 (4th ed. 1971)).

Armstrong, P.S.C. v. Gunderson, 279 S.W.3d 93, 113 (Ky. 2008). The law is also clear as to when a physician's legal duty to a patient begins: "The physician's duty to a patient arises when, by his words or deeds, 'he agrees to treat a patient, thus establishing a physician/patient relationship.'" *Jenkins v. Best*, 250 S.W.3d 680, 688 (Ky. App. 2007) (quoting *Noble v. Sartori*, 799 S.W.2d 8, 9 (Ky. 1990)). That overarching duty continues and applies uniformly throughout the duration of the physician/patient relationship, embracing every medical responsibility, whether that responsibility is:

(1) taking the patient's history; or

(2) diagnosing his illness; or

(3) administering anesthesia; or

(4) treating his ailment; or

(5) informing him of risks and options; or

(6) performing surgery; or

(7) engaging in post-operative care;

or conducting any of the myriad of acts necessary to the administration of medical care to the patient. Each of these separate medical responsibilities must be fulfilled in accordance with the medical profession's expectations; failure to fulfill a responsibility constitutes a breach of the overarching legal duty identified in *Hyman & Armstrong*. This is not a new concept.

VanMeter v. Crews, 149 Ky. 335, 148 S.W. 40 (1912), held that while only one recovery may be had for a physician's medical negligence, liability may be

premised separately on one or more deviations from the standard of care – that is, there is but one duty, but the possibility of multiple breaches, just as Horsley's complaint alleged. To quote *VanMeter*:

> The plaintiff had employed the defendant as her physician, and had placed herself in his charge. If he operated on her without her consent[, or what today we would call "informed consent"], this was a *breach* of his duty to her; if he performed the operation unskillfully, this was also a *breach* of his duty. In other words, all that the defendant did was done by him as a physician, and under his employment as such. The status of physician and patient existed, and all that he did was done under this relationship. . . . Her whole case arises from the defendant's breach of duty as a physician, and she may, in one action, set up *as many breaches* of duty as exist.

VanMeter, 148 S.W. at 42 (emphasis added).

With but one exception which we shall discuss later,[3] we have never deviated from the approach in *VanMeter*, but followed it through an evolving jurisprudence and despite legislative tinkering (as also discussed *infra*). As discussed below, we have steadfastly applied the bare-bones approach and stuck with a single instruction defining the whole duty of the physician to his patient whether the breach alleged was a physician's:

> (1) "failure to consider the history given by the patient[,]" *Mackey v. Greenview Hosp., Inc.*, 587 S.W.2d 249, 254 (Ky. App. 1979);
>
> (2) "failure to timely diagnose and treat" the patient's disease, *Dennis v. Fulkerson*, 343 S.W.3d 633, 634 (Ky. App. 2011);

[3] *Oghia v. Hollan*, 363 S.W.3d 30 (Ky. App. 2012).

(3) "improperly administer[ing] anesthesia[,]" *Cohen v. Alliant Enters., Inc*., 60 S.W.3d 536, 538 (Ky. 2001) (citing *Copeland v. Humana of Kentucky, Inc*., 769 S.W.2d 67 (Ky. App. 1989);

(4) "failure adequately to inform the patient" of risks associated with treatment, *Keel v. St. Elizabeth Medical Ctr.*, 842 S.W.2d 860, 862 (Ky. 1992);

(5) "negligence . . . in performing the surgery[,]" *Engle v. Clarke*, 346 S.W.2d 13, 15 (Ky. 1961).

(6) "improper treatment[,]" *Johnson v. Vaughn*, 370 S.W.2d 591, 597 (Ky. 1963);

(7) "get[ting] beyond the field of the operation and injur[ing] some sound portion of the patient's body not involved in the operation," *Fields v. Rutledge*, 284 S.W.2d 659, 661 (Ky. 1955); or

(8) "negligence . . . in postoperative care[,]" *Engle v. Clarke*, 346 S.W.2d 13, 15 (Ky. 1961).

In none of these cited cases did the court give a separate jury instruction, specific to the identified medical responsibility, to supplement the general legal duty instruction.[4] A second, more specific instruction risks improperly "giv[ing] undue prominence to certain facts and issues." *Fields*, 284 S.W.2d at 662.

There have been several attempts to fracture the general legal duty into legal sub-duties and, through multiple jury instructions, to focus a jury's attention upon specific medical responsibilities rather than upon the general legal duty. As a matter of course, those attempts have been rejected.

[4] However, the single, general duty instruction often and not improperly contains modifications attuned to the circumstances. The instruction in *Hamby v. Univ. of Kentucky Medical Ctr.*, 844 S.W.2d 431 (Ky. App. 1992), *infra*, is an example of such fine-tuning of the duty instruction.

One example is *Fields v. Rutledge*. In *Fields*, the plaintiff claimed a surgeon was negligent in performing a tonsillectomy on a six-year-old girl. *Id.* at 660. Removal of the tonsils themselves went well enough; however, the surgeon dealt with two incisors obstructing his access by extracting them, believing them to be "baby teeth" when, in fact, they were permanent teeth. *Id.* In *addition* to the general duty instruction, the plaintiff wanted an instruction that the physician had a duty "'to ascertain whether the teeth involved were permanent or baby teeth and to take such precautions as are usually taken in such cases to avoid damage to or destruction of such teeth.'" *Id.* at 662 (quoting plaintiff's proposed jury instruction). The trial court refused the instruction and Kentucky's highest court affirmed, identifying "the error in the instruction offered by plaintiff of giving undue prominence to the teeth." *Id.*; *see also Rogers v. Kasdan*, 612 S.W.2d 133, 136 (Ky. 1981) (citing *Fields* for this concept as the foundation of bare-bones jury instructions).

In another medical negligence case, *Hamby v. Univ. of Kentucky Med. Ctr.*, 844 S.W.2d 431 (Ky. App. 1992), involving an experimental cancer treatment, the trial court instructed the jury on duty as follows:

> It was the duty of the defendant [physician] in the diagnosis, care and treatment of [the plaintiff], to exercise that degree of care and skill expected of an ordinary, prudent and competent physician specializing in radiation oncology and trained in the use and administration of hyperthermia.

Id. at 433. The plaintiff wanted additional, separate duty instructions listing, among other medical responsibilities, "a duty to obtain informed consent . . . ." *Id.* This Court roundly rejected the idea that more was needed than the single instruction given. To the point, "[w]e disagree[d] that the specific enumerated duties should have been included in any instruction." *Id.* We said medical negligence cases are not like auto accident cases in which we are "used to enumerat[ing] specific duties . . . [On the contrary,] we have traditionally excluded them in medical malpractice cases."[5] *Id.* Simply put, a trial court conducting a medical negligence case does "not commit reversible error by refusing to include specific duties in its instructions." *Id.* at 433 fn1. *Hamby* then reiterated the following longstanding axiom:

> The general rule for the content of jury instructions on negligence is that they should be couched in terms of duty. They should not contain an abundance of detail, but should provide only the bare bones of the question for jury determination. This skeleton may then be fleshed out by counsel on closing argument.

Id. at 433 (quoting *Rogers v. Kasdan*, 612 S.W.2d 133, 136 (Ky. 1981)); *see also Bayless v. Boyer*, 180 S.W.3d 439, 450 (Ky. 2005) (refusing to overrule "*Cox v. Cooper*, 510 S.W.2d 530 (Ky.1974), which held that jury instructions 'should provide only the *bare bones*, which can be fleshed out by counsel in their closing arguments if they so desire.' *Id.* at 535.").

Specifically addressing lack-of-informed-consent claims, our highest court long ago rejected the idea that such claims should be treated differently than other

[5] For an explanation why medical negligence cases are different, see footnote 2, *supra*.

failures of medical responsibilities. *Holton v. Pfingst,* 534 S.W.2d 786 (Ky. 1975). Rather, Kentucky courts "regard the failure to disclose a mere risk of treatment as involving a collateral matter . . . and so have treated the question as one of negligent malpractice only, which brings into question professional standards of conduct." *Id.* at 788 (quoting W. Prosser, *Handbook of the Law of Torts*, 106 (4th ed. 1971)). "[T]he action, regardless of its form, is in reality one for negligence in failing to conform to a proper professional standard." *Id.*

Perhaps the most direct explanation of the role played by lack-of-informed-consent issues in our jurisprudence was offered by Justice Leibson.

> "Lack of informed consent" is not, *per se*, a tort. It is only a term useful in analyzing . . . the type of negligence which occurs when a physician has not made a "*proper disclosure* of the risks inherent in a treatment." Louisell and Williams, *Medical Malpractice*, Vol. 2, Sec. 22.04. (Emphasis original.)

Keel v. St. Elizabeth Med. Ctr., 842 S.W.2d 860, 862-63 (Ky. 1992) (Liebson, J., concurring).

The upshot of these cases is that lack of informed consent is not deserving of special treatment, distinct from the many other ways a physician's failure to satisfy a medical responsibility may lead to his or her breach of a legal duty. Lack of informed consent simply identifies a way to breach the physician's duty; it does not define the duty itself.

Our view is not affected by Horsley's citation to two of our own opinions: *Campanell v. Figert*, 2008-CA-000062-MR, 2009 WL 1424069 (Ky. App., May

22, 2009) and *Oghia v. Hollan*, 363 S.W.3d 30 (Ky. App. 2012). Neither of these cases stands for the principle that separate jury instructions must be given to define the general duty of care *and* the specific responsibility to obtain informed consent. We first consider the unpublished opinion, *Campanell*.

Campanell has no precedential value. CR[6] 76.28(4)(c). Even if it did, the case would work against Horsley's argument. We said "[t]he trial court *properly* instructed the jury" as follows:

> It was the duty of the Defendant [physician] in advising and/or treating Plaintiff . . . to exercise the degree of care and skill expected of a reasonably competent physician specializing in general surgery and acting under similar circumstances.

Campanell, 2009 WL 1424069, *2-*3 (emphasis added). There was no other duty instruction and that, too, was proper. "Informed consent was at issue in the case only insofar it related to the standard of care" which the medical profession expected of a competent physician under similar circumstances. *Id.* at *3. The circuit court in *Campanell* instructed the jury virtually identically to the manner in which the circuit judge in the case now before us instructed Horsley's jury. Both are consistent with our analysis that whether the general legal duty was breached by the physician's failure to meet one or more medical responsibility is to be fleshed out in closing argument, not presented to the jury as a "list of ways in which a defendant must act in order to meet his duty." *Rogers*, 612 S.W.2d at 136.

[6] Kentucky Rules of Civil Procedure

However, Horsley points us to a particular passage in *Campanell* "that instructions should not blend distinct legal concepts. Liability can be premised separately based on lack of informed consent and deviation from the standard of care." *Id.* We interpret this bit of unpublished *dicta* consistently with established case law and our analysis that lack of informed consent is not a separate tort. At most, this passage is an unartful way of saying what was first said more than a hundred years ago in *VanMeter*, *supra*.

Our understanding of *Campanell* does not diminish our analysis; it strengthens it. We now turn to *Oghia v. Hollan*.

In *Oghia*, the issue was not, as it is here, whether the trial court was *required to give a separate instruction* on lack of informed consent. On the contrary, relying on the concept of bare-bones pleading, Dr. Oghia argued that the trial court was *required **not** to give a separate instruction* on lack of informed consent. At the time, this Court[7] embraced the concept of bare-bones jury instructions, then rejected it as a basis of Dr. Oghia's argument, saying:

> We agree with Dr. Oghia that Kentucky jury instructions should be bare bones. However, we do not agree with Dr. Oghia that this overriding principle limits a judge's ability to instruct on separate duties of care, if appropriate. As noted by Hollan, the evidence indicated that Dr. Oghia had two duties of care – [(1)] to treat Hollan with the care and skill of a reasonably competent surgeon and [(2)] to disclose to Hollan the risks associated with surgery as a reasonably competent surgeon would. Because the evidence supported the issuance of two separate duty-of-care jury instructions, we discern no error therein.

[7] That is to say, a different panel of this Court.

Oghia, 363 S.W.3d at 33.

Oghia ignores the fact that the doctor's second so-called duty is merely one of a subset of responsibilities expected of and subsumed by the first duty the court listed – the duty *VanMeter* simply refers to as his "duty as a physician[.]" *Oghia* also ignores the fact that once a jury is instructed as to the first duty, a second instruction is a redundancy that brings undue attention to it. *Oghia* held that the trial court was *not prohibited from* instructing separately on informed consent, thereby reaching the exact opposite conclusion reached in *Hamby*. *Hamby*, 844 S.W.2d at 433 (rejecting argument that "the instructions should have included (1) a duty to obtain informed consent . . . .").

Despite our disagreement with *Oghia*, our holding in the case now before us is not inconsistent because we are holding that the trial court was *not compelled to* instruct separately on informed consent. However, as we shall further discuss, our holding today is on a far sounder footing than *Oghia*.

Although *Oghia* calls the bare-bones-pleading principle "overriding," we certainly did not treat it as such in that case.[8] We cannot ignore or escape the fact that, as no other case has before or since, *Oghia* marginalized the "overriding principle" of bare-bones pleading in medical malpractice cases and the analysis of cases such as *Fields, Rogers, Bayless,* and *Cox*, and the "long line of Kentucky cases which call for a substantially similar approach." *Bayless*, 180 S.W.3d at 450.

[8] The term "overriding" is defined as "taking precedence over all other considerations." Random House Dictionary of the English Language 1384 (2nd ed. 1987).

We deem *Oghia* an aberration.[9] In any event and as noted above, it addresses a different question than that now before us. It is not precedent we must follow, and it is not persuasive authority we choose to follow. We move on to Horsley's next argument.

Horsley makes a separate argument based on KRS 304.40-320(2), stating it "place[s] a statutory duty on [Dr. Smith] regarding informed consent." (Appellant's brief, p. 8). He quotes the statute with highlighting we repeat here:

> (2) A reasonable individual, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedure **and medically** or dentally **acceptable alternative procedures or treatments and substantial risks and hazards** inherent in the proposed treatment or procedures which are recognized among other health care providers who perform similar treatments or procedures;

He then states: "Because [Dr. Smith] had a statutory duty, [Horsley] was entitled to an instruction regarding that duty."

To determine whether Horsley is correct, we have analyzed the statutory language, the legislative history, and our jurisprudence before, after and during the discussion and enactment of KRS 304.40-320. We conclude that the statute creates no separate duty that would entitle a plaintiff to a second, separate jury instruction.

[9] Dr. Oghia did not seek discretionary review by the Kentucky Supreme Court. Whether the case would have survived such review, we do not know. Nor need this Court sit *en banc* to consider whether this case overrules *Oghia* since the cases do not address the same question. Supreme Court Rule (SCR) 1.030(7)(d) ("If prior to the time the decision of a panel is announced it appears that the proposed decision is *in conflict with the decision of another panel on the same question*, the chief judge *may* reassign the case to the entire court." (emphasis added)).

The passage Horsley quotes lacks context.[10] In context, it literally identifies the circumstances under which "the claimant's informed consent shall be deemed to have been given[.]" KRS 304.40-320. Far from creating a statutory duty, it implies the existence of a safe harbor for the health care provider who is able to establish the existence of the circumstances described in the statute.

Some statutes, of course, do establish duties, but their language makes that duty clear by use of obligatory words such as "shall" and "must" that compel conduct by the target of their regulation. For example, KRS 214.155 requires that "[t]he Cabinet for Health and Family Services *shall* operate a newborn screening program for heritable and congenital disorders[.]" KRS 214.155(1) (emphasis added). Similarly, the federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd,[11] states that a "hospital *must* provide for an

[10] KRS 304.40-320 is entitled "Informed consent; when deemed given" and states in its entirety as follows:

> In any action brought for treating, examining, or operating on a claimant wherein the claimant's informed consent is an element, the claimant's informed consent shall be deemed to have been given where:
> (1) The action of the health care provider in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with the accepted standard of medical or dental practice among members of the profession with similar training and experience; and
> (2) A reasonable individual, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedure and medically or dentally acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other health care providers who perform similar treatments or procedures;
> (3) In an emergency situation where consent of the patient cannot reasonably be obtained before providing health care services, there is no requirement that a health care provider obtain a previous consent.

[11] EMTALA "is sometimes referred to as an 'anti-dumping' statute because its primary purpose is to prevent hospitals from 'dumping' patients who lack insurance or cannot pay for their claims, through refusing treatment or referring them to other hospitals." *Martin v. Ohio County Hosp. Corp.*, 295 S.W.3d 104, 112 (Ky. 2009) (citing *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131 (6th Cir.1990)).

appropriate medical screening examination" and specifically creates a right in favor of a patient to bring "a civil action against the participating hospital" that fails to comply with the statute. 42 U.S.C. § 1395dd(a), (d)(2)(A) (emphasis added). Even with this language relating to a hospital's duty, a duty that could only be satisfied (or breached) by human beings, the statute did "create a federal malpractice cause of action" to be brought against medical professionals who "shirk screening an indigent person or transfer that person to another hospital . . . ." *Martin v. Ohio County Hosp. Corp.*, 295 S.W.3d 104, 112 (Ky. 2009).

Returning to our statute, KRS 304.40-320, we see that, in fact, it does use the obligatory verb "shall," but not in a context necessary to compel a health care provider's compliance with the statute. Rather, it compels a court to hold, upon finding the circumstances set out in the statute, that "informed consent shall be deemed to have been given[.]"

When we move beyond the language of the statute to consider its history, it becomes even clearer that the legislature did not intend to create new rights for claimants or make claims easier. In fact, for better or worse, the legislative history shows the opposite intent.

The timing of the statute's enactment in 1976 is significant. Less than two years earlier, "the cost and availability of [medical] malpractice liability coverage in Kentucky reached a situation of crisis proportion." R. David Clark, *Medical*

Malpractice, 65 KY. L.J. 337, 338 (1976).[12] This perceived malpractice insurance crisis was caused by an increase in the number of medical malpractice suits. And what caused that increase? "Several professors from Harvard's School of Public Health and School of Medicine provide a summation of the reasons for the rise in medical malpractice suits in the 1970s[.]" William J. Phelan, IV, *A Chronic Concern No More: How Federal Medical Malpractice Caps Will Survive Under the Equal Protection Clause of the United States Constitution*, 23 J. Contemp. Health L. & Pol'y 168, 173 (Fall 2006) (citing David Studdert *et al.*, *Medical Malpractice*, New Eng. J. Med. 284 (2004) (citations omitted)). They explained, generally, that, across the country, "[j]udges discarded rules that had traditionally posed obstacles to litigation. For example, most jurisdictions rolled back charitable immunity for hospitals." *Id.* (citation omitted). That happened in Kentucky in 1961. *Mullikin v. Jewish Hosp. Ass'n of Louisville*, 348 S.W.2d 930, 935 (Ky. 1961) ("We are impelled by right and reason to reverse our previous holdings and hold that the charitable nature of an institution is not sufficient within itself to give immunity from liability for its tort.").

Additionally, "[c]ourts also moved toward national standards of care and abandoned strict interpretations of the 'locality rule,' which had required plaintiffs to find expert witnesses within the defendant's immediate practice community."

[12] For example, between 1960 and 1970, "[p]remiums rose nationally . . . for physicians other than surgeons, 540.8 percent; and for surgeons . . . , 949.2 percent." Clark, *supra*, at 337 n.6. "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 . . . sought an additional 200 percent increase." *Id.* at 338 n. 8.

Phelan, *supra*, at 173. That happened in Kentucky in 1970 when our highest court said,

> We agree . . . that the proper standard should not be expressed to the jury in terms of 'community' practice. Under our system of jury instructions, we have often rejected the notion that one particular circumstance should be emphasized by specification when other relevant circumstances are generalized under the phrase, 'the same or similar circumstances.' . . . It is our conclusion that the jury should be instructed that the defendant was under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances.

Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. 1970).[13]

"At the same time, *expansion of doctrines such as informed consent* and *res ipsa loquitur* . . . paved new pathways to the courtroom." Phelan, *supra*, at 173 (emphasis added). It was in the midst of the malpractice insurance crisis, and the legislative efforts to solve it, that our highest court first considered "the so-called doctrine of 'informed consent[.]'" *Holton v. Pfingst*, 534 S.W.2d 786, 788 (Ky. 1976). Let us return to considering that 1970s crisis.

[13] *But see Keel v. St. Elizabeth Med. Ctr.*, where the Court, in a plurality opinion, confused the bar by stating: "we have no hesitation in . . . holding that expert testimony is required in informed consent cases to establish whether a reasonable medical practitioner *in the community* would make the pertinent disclosures under the same or similar circumstances." 842 S.W.2d at 866 (emphasis added). The Court, certainly errantly, re-injected the community standard, or "locality rule," into its interpretation of the statute by comparing Kentucky legislation to similar legislation from Florida and North Carolina. According to the Court, those states "have statutes similar to KRS 304.40-320[.]" *Id.* at 865-66. On the point of the locality rule, that was inaccurate. Both Florida and North Carolina retained the locality rule in their respective statutes. *Id.* at 865 n. 2 ("Florida's statute [applies the standard of care adhered to by] other physicians . . . [in] the same or similar community[.]"); *id.* at 865 n. 3 ("North Carolina's informed consent statute [applies the standard of care adhered to by] other health care providers . . . in the same or similar communities[.]"). Kentucky's statute, KRS 304.40-320, has never included the community standard or locality rule. KRS 304.40-320.

Across the country, "state legislatures responded to the perceived medical malpractice crises with a range of legislative reforms in both insurance law and tort law." Jean Macchiaroli Eggen, *Medical Malpractice Screening Panels: An Update and Assessment*, 6 J. Health & Life Sci. L. 1, 7 (June 2013). Our own Governor appointed a committee of legal and medical professionals, known as the Governor's Hospital and Physicians Professional Liability Insurance Advisory Committee, to consider legislative solutions. Clark, *supra*, at 338; J. Vaughn Curtis, Comment, *Informed Consent in Kentucky After the Medical Malpractice Insurance and Claims Act of 1976*, 65 KY. L.J. 524, 525 n. 8. (1976). "The final report of the Committee in bill form was enacted by the General Assembly with minor changes" as the Medical Malpractice Insurance and Claims Act, KY. ACTS ch. 163 (1976) (the Act).[14] Curtis, *supra*, at 525 n. 8.

The Act had three major components,[15] but only the third is relevant to our analysis. That third component described "procedural and substantive legal standards for handling malpractice litigation [in an] attempt to make it more difficult to bring a successful malpractice suit." *Id.* at 526. Section 8 of the Act, addressing informed consent, specifically "sought to create a standard for informed

[14] KRS 304.40-250-.330. The Committee also drafted the Joint Underwriting Association Act, but that Act is not relevant to our analysis.

[15] The first and principal component, contained in § 9 and § 10 of the Act, established a patient's compensation fund to provide "umbrella" coverage for physicians and hospitals. Curtis, *supra*, at 525. This part of the Act was held unconstitutional in *McGuffey v. Hall*, 557 S.W.2d 401, 416 (Ky. 1977). A second component, contained in § 7 and enacted as KRS 304.40-310, "makes a minimal commitment to the reduction of malpractice itself" by requiring a report "to the appropriate licensure board or regulatory agency for review" following settlement or other disposition of a malpractice claim. *Id.*

consent cases that would minimize the plaintiffs' chances for success." *Id.* at 539.

The Committee "explained the intent of" what became KRS 304.40-320:

> This section will legislatively require that "informed consent" cases be proven by expert testimony relating to accepted standards of practice of the profession in providing information, and further require that an objective standard be applied in determining whether that information would likely have resulted in any different decision by the plaintiff.
>
> The purpose of this section is to eliminate the possibility of (1) a jury's speculating after the fact that the health care provider would have told the plaintiff of a given risk even though accepted professional standards would not require such advance information, and (2) a plaintiff's testifying that had he known of an unforeseeable or unlikely injury he would not have consented to the recommended health care.

Id. at 537, 538 (quoting Governor's Hospital and Physicians Professional Liability Insurance Advisory Committee, Governor's Report, § II, at 5).

The Committee's statement of intent and purpose regarding KRS 304.40-320 has only been analyzed once in our jurisprudence. In *Keel*, *supra*, Special Justice Ronald M. Sullivan, writing in dissent, quoted the same passage set out above and stated:

> In sum, KRS 304.40-320 mandates that the plaintiff satisfy two requirements in an informed consent case. First, the plaintiff must prove that the disclosure made by the health care provider did not satisfy the accepted standard of the members of that profession with similar training and experience. Second, plaintiff must prove that a reasonable individual would not understand the procedures, acceptable alternatives, and the substantial risks inherent in the proposed treatment from the health care provider's disclosures.

Keel, 842 S.W.2d at 865 (Sullivan, S.J., dissenting). Chief Justice Stephens and Justice Spain joined Special Justice Sullivan in this dissent. Justice Leibson concurred with the plurality[16] in result only, expressing his belief that the statute was unconstitutional, and stating, "[c]onstitutionally, the statute cannot define the duty." *Keel*, 842 S.W.2d at 863 (Leibson, J., concurring in result only).

This Court believes it was never the intention of the legislature to establish a duty, but merely to describe how, as to the medical responsibility of obtaining informed consent, the physician's duty to a patient, by compliance with the statute, can be satisfied. *See Fraser v. Miller*, 427 S.W.3d 182, 187 (Ky. 2014) (Keller, J., concurring) ("KRS 304.40-320 does not require a physician to obtain informed consent[;] it simply states when informed consent shall be deemed to have been obtained.").

Horsley's argument that the statute created a new duty is clearly antithetical to the statute's purpose to "minimize the plaintiffs' chances for success." Curtis, *supra*, at 539. Furthermore, there was never a need, nor was it ever the legislative purpose, to create a statutory cause of action here. It would be absurd to conclude, in the climate of a perceived malpractice crisis, that our legislature intended to create a separate duty – *i.e.*, an expansion of liability for physicians for the breach

[16] The plurality opinion was written by Justice Dan Jack Combs with whom Justices Lambert and Wintersheimer concurred. As noted, Justice Leibson concurred in result only.

of the duty owed by every physician to his patient – where such a responsibility, in a variety of evolving forms, has long existed at common law.[17]

Based on the foregoing analysis, we conclude that the trial court did not err by refusing Horsley's second proposed, supplemental jury instruction.

The trial court did not err by excluding Horsley's tendered exhibit.

We review a trial court's ruling as to the admissibility of evidence under an abuse of discretion standard. *Goodyear Tire & Rubber Co. v. Thompson*, 11 S.W.3d 575, 577 (Ky. 2000).

Horsley challenges the trial court's refusal to admit as an exhibit a copy of the AMA Guidelines. We find no abuse of discretion here.

The circuit court allowed counsel to use the guidelines during Dr. Smith's cross-examination, but denied their introduction as exhibits. That denial was proper pursuant to KRE[18] 803(18), which governs the admission of learned treatises. The Rule explicitly states that while the statements contained in them may be read into evidence, they "may not be received as exhibits." Accordingly, the trial court properly refused to admit them as exhibits.

The trial court did not err by overruling Horsley's motion for directed verdict.

[17] The earliest reference we could find in Kentucky jurisprudence to a physician's liability for failing to obtain consent before treating is, sadly, a property case. In *Hord v. Grimes*, the Court held that "[a] physician is responsible for all the ill consequences which may result from the administration of medicine to a slave without the consent of the owner." 13 B.Mon. 188, 188, 52 Ky. 149, 149, 1852 WL 3388, *1 (1852).

[18] Kentucky Rules of Evidence

Horsley argues the circuit court erred by refusing to grant his motion for a directed verdict on the issue of informed consent. But this argument also fails.

Our research shows that a directed verdict in favor of the plaintiff is rather rare. "It is only when *all the evidence* tends to support the cause of action alleged *and* to disprove the defense that the court should peremptorily instruct a verdict for the plaintiff." *Thomas Jefferson Fire Ins. Co. v. Barker*, 251 S.W.2d 862, 863 (Ky. 1952) (emphasis added). Horsley's argument does not consider *all the evidence*.

Horsley quotes portions of Dr. Smith's cross examination testimony and claims this evidence constitutes the doctor's admission that he chose the method of administering anesthesia without "giving him [Horsley] an option[.]" However, he ignores evidence that makes it clear the issue was for the jury.

Most notably, there is the written "Informed Consent For Cataract Surgery" that says, "The ophthalmologist or the anesthesiologist/nurse will make your eye numb with either drops or an injection (local anesthesia)." Horsley initialed this and every other page and signed the consent form at the end. There is no evidence that Horsley failed to appreciate the distinction between the two methods of anesthetization. He underwent the same surgery on his other eye which was also preceded with anesthesia by injection. The record indicates that Horsley raised no objection either to the injection or the numbing drops. His consent, therefore, was consent to both methods.

Here, the evidence was that consent was express. However, under Kentucky law, consent "need not be express, but may be implied from the surrounding facts

and circumstances." *Kovacs v. Freeman*, 957 S.W.2d 251, 255 (Ky. 1997) (citing *Haywood v. Allen*, 406 S.W.2d 721, 722 (Ky. 1966)); *see also Hoofnel v. Segal*, 199 S.W.3d 147, 150 (Ky. 2006) ("[V]alid consent . . . is to be gleaned from evidence of the circumstances and discussions surrounding the consent process." (citing *Kovacs* and *Haywood*; quotation marks omitted)). The case before us has strong analogies to *Haywood v. Allen*, notwithstanding that *Haywood* involved implied consent.

In *Haywood*, a physician consulted with a woman and her husband about the delivery of their child by Caesarian section. *Haywood*, 406 S.W.2d at 722. The consultation included discussion of a contemporaneous tubal ligation and the two procedures "were discussed as a 'package deal'[.]" *Id.* The Court concluded that "there was a tacit understanding that the ligation would be performed during the Caesarean *unless* Mrs. Haywood should tell the doctor that she did not want the ligation." *Id.* (emphasis added). The evidence was that Mrs. Haywood did not speak up and the court held that her failure to object amounted to her implied consent. *Id.*

Like Mrs. Haywood, Horsley did not speak up after being informed that the procedure to which he later objected was an option. Under the circumstances, it was Dr. Smith's option. Horsley's objection to the one option of injection, had he made one, would have deprived Dr. Smith of that option and effectively revoked consent for the injection. But Horsley remained mute. It is unquestionably reasonable and possible that the jury took this view of the evidence when it

rendered a verdict in favor of Dr. Smith. The jury's verdict here is not palpably or flagrantly against the evidence so as to justify reversing denial of Horsley's directed verdict motion. *Lewis v. Bledsoe Surface Min. Co.*, 798 S.W.2d 459, 461 (Ky. 1990).

It is impossible to say that all the evidence in this case tended both to support Horsley's cause of action and to disprove Dr. Smith's defense. Having reviewed the record and considered the arguments, we find no error in the trial court's denial of Horsley's directed verdict motion.

The trial court did not err by failing to strike Smith's Answer to the Complaint.

We review a trial court's decision to sanction a party, by any means including striking a pleading, for abuse of discretion. *Potter v. Eli Lilly & Co*., 926 S.W.2d 449, 454 (Ky. 1996) *abrogated by Hoskins v. Maricle*, 150 S.W.3d 1 (Ky. 2004) ("implied powers [are] vested in the court to manage its own affairs so as to achieve the orderly and expeditious, accurate and truthful disposition of causes and cases. . . . [S]uch authority is vested in the sound discretion of the court[.]"); *Morton v. Bank of the Bluegrass & Trust Co*., 18 S.W.3d 353, 360 (Ky. App. 1999) ("Sanctions [imposed under CR] 37.02 are within the trial court's discretion.").

Horsley argues that the trial court erred in denying his motion to strike Dr. Smith's answer and failing to enter a default judgment due to what Horsley calls "egregious and repeated lies under oath." The sanctions imposed by the trial court were not an abuse of the trial court's discretion. For the following reasons, Horsley's argument fails and we affirm the trial court on this issue.

During Dr. Smith's first deposition, Horsley's counsel questioned him about two newspaper articles that were mailed anonymously to Horsley prior to the lawsuit. The articles recounted cases of physicians suing attorneys who had filed unsuccessful malpractice actions against them. In the deposition, Dr. Smith denied any involvement, but shortly after the deposition ended, Dr. Smith contacted his attorney and confessed to mailing the letters.

Dr. Smith's confession led to his own re-deposition by Horsley's counsel, during which he acknowledged both the lie and the cover-up. Horsley moved for heavy sanctions, requesting that the circuit court strike Dr. Smith's answer and enter a default judgment. The court denied Horsley's request, reasoning that while Dr. Smith's conduct was egregious, it was quickly remedied before any prejudice to Horsley's case.

Instead, the court held Dr. Smith in contempt, ordered him to "reimburse [Horsley's] counsel for all reasonable expenses, including costs and attorneys' fees, associated with bringing the motion for sanctions, the motion for a [related] protective order, and the second deposition." (R. 353). Dr. Smith was also ordered to pay a $7,500 fine to the court. The court also ordered that "[t]he fact that Dr. Smith gave false testimony in his deposition shall be admissible at the trial [and] forwarded [a copy of the sanctioning order] to the Kentucky Board of Medical Licensure for any further action it deems appropriate." (*Id.*).

In evaluating the trial court's decision, we note that a default judgment is strong medicine that "should be resorted to only in the most extreme cases." *R.T.*

Vanderbilt Co., Inc. v. Franklin, 290 S.W.3d 654, 661 (Ky. App. 2009). Usually, such cases involve repeated or particularly flagrant instances of misconduct that prejudice the opposing party. Unlike those cases, Dr. Smith made a single isolated, albeit egregious, error in judgment. While serious, Dr. Smith quickly and voluntarily admitted to his misdeeds well before trial, thus avoiding the prejudice to Horsley that may have warranted more severe sanction.

The trial court's sanctions seem to us just and proportionate but, more importantly, the decision to deny Horsley's motion to strike the Answer in favor of the sanctions imposed was well within the discretion of the trial court. We find no abuse of discretion here.

CONCLUSION

Fore the foregoing reasons, the judgment of the Jefferson Circuit Court is affirmed.

VANMETER, JUDGE, CONCURS.

DIXON, JUDGE, DISSENTS AND WILL NOT FILE SEPARATE OPINION.

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