1964

Medical Malpractice in Kentucky

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Recommended Citation
Henderson, Marvin (1964) "Medical Malpractice in Kentucky," Kentucky Law Journal: Vol. 53 : Iss. 1 , Article 11.
Available at: https://uknowledge.uky.edu/klj/vol53/iss1/11

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MEDICAL MALPRACTICE IN KENTUCKY

In recent years the medical profession has been made acutely aware of the liability to which physicians are subjected when they fail to utilize the proper standard of care in the treatment of their patients. It is common knowledge that medical malpractice suits have been on the increase in jurisdictions such as California and New York. No such increase has been noted from the appellate court decisions in Kentucky, however. Yet, two recent decisions by the Court of Appeals have renewed the problem of medical malpractice in Kentucky. These are the cases of Engle v. Clarke and Johnson v. Vaughn.

In the Engle case negligence was alleged in the performance of surgery for an epigastric hernia and in the postoperative care which caused the patient's death. The cause of death was a hemorrhage in the peritoneal cavity following the surgery. The plaintiff's theory was that the hemorrhaging was caused through the slippage of a ligature used to tie off the round ligament of the liver during surgery and that the surgeon was negligent in using only one ligature instead of two in order to guard against slippage. An expert witness, a surgeon, testified for the plaintiff that surgeons always tied off the ligament with two ligatures. The Court of Appeals held that a directed verdict for the doctor was proper because there was no testimony as to what was ordinary and customary in the community or in similar communities with respect to the number of ligatures normally used. "Without any evidence in this respect there was no basis on which the jury properly could have found Dr. Scott negligent in failing to use more than one ligature." As to the postoperative negligence in the failure to diagnose the internal hemorrhaging, the Court of Appeals held that the evidence was insufficient to show negligence as a matter of law and the jury's verdict should not be disturbed since the evidence was not so clear and convincing that reasonable men would not differ in their conclusions.

The Johnson case involved several acts or omissions which were

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1 Publications of the medical profession carry constant and often somewhat subtle reminders of professional liability. One of the most important of these is the bi-monthly publication Medical Economics which often carries short articles written by defense attorneys or by insurance adjusters. Such articles contain illustrations of out of court settlements of "unjustified" claims and subtle hints of how they cause the insurance rates of every doctor in the community to be raised. See Warren, Malpractice Mishaps: The Case of the Costly Cocktails, Medical Economics, Dec. 8, 1968, p. 179.
2 346 S.W.2d 13 (Ky. 1961).
3 870 S.W.2d 591 (Ky. 1963).
4 346 S.W.2d at 15.
alleged to constitute malpractice on the part of the defendant. The
decedent was taken to a hospital with a small caliber gunshot wound
in the neck. The defendant arrived at the hospital in response to the
emergency call. There was evidence that the doctor was intoxicated
when he came into the emergency room. There was evidence from
which the jury could have found that the doctor failed to give proper
medical treatment in that he did not administer a transfusion and
did not perform a tracheotomy. The doctor left the hospital to change
his clothes and did not return. He refused to release the patient to
another physician when the patient grew worse unless he was paid
$50. The patient died from an embolism resulting from air escaping
from a hole in the trachea and entering the blood during surgery
performed by the second physician after the defendant finally agreed
to release the patient.

The Court of Appeals held that the evidence of negligence was
sufficient to allow the case to go to the jury. There was evidence of
negligence in improper treatment, abandonment of the patient at a
crucial time, and in unreasonably delaying consent for another
physician to undertake to treat the patient. The court failed to dis-
cuss the standard of skill and care required under the circumstances,
and indeed, there was no evidence of the standard of care and skill
under the circumstances of physicians in the community or in similar
communities. Thus, we see that the court in the Johnson case may
have retreated from its position in the Engle case, that negligence
could not be found absent proof of the standard of care and skill
of physicians in the community or in similar communities under like
circumstances. Of course, the cases could be distinguished in that
the Johnson case was a stronger case for negligence on its facts.

The problem of medical malpractice is not a new one in Kentucky. The
following table shows the distribution of 55 medical malpractice
cases surveyed as to the years in which they were decided by the
Court of Appeals. It should be noted that not all of these cases were
against physicians directly. Three cases were against the employer
of a physician. Two cases involved negligence on the part of a

5 Brief for Appellee, p. 13, Johnson v. Vaughn, 370 S.W.2d 591 (Ky. 1963).
6 As early as 1851 the Court of Appeals considered a malpractice case. See
Piper v. Menifee, 51 Ky. 465, where the doctor brought an action for his bill and
the patient used his negligence as a set-off and counterclaim. The court reversed
in order to permit the counterclaim.
7 Western Union Telegraph Co. v. Mason, 232 Ky. 237, 22 S.W.2d 692
(1929); Black Mountain Corp. v. Thomas, 218 Ky. 497, 291 S.W. 737 (1927);
Ballard v. Chespeake and O. Ry., 144 Ky. 476, 139 S.W. 771 (1911). These
cases set forth the proposition that the employer of a physician is not liable for
the physician's negligence in treating a third person at the employer's order.
dentist; one of which was appealed twice. One case did not involve negligence, but assault and battery.

### TABLE A

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Cases Decided</th>
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<tr>
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8 Tanner v. Sanders, 247 Ky. 90, 56 S.W.2d 718 (1933); Donoho v. Rawleigh, 230 Ky. 11, 18 S.W.2d 311 (1929).
9 Rawleigh v. Donoho, 238 Ky. 480, 38 S.W.2d 227 (1931).
10 Tabor v. Scobee, 254 S.W.2d 474 (Ky. 1952), holding that where, in performing an appendectomy on a young unmarried woman, the surgeon proceeded to remove her diseased Fallopian tubes, such constituted a battery since consent was not obtained and no emergency existed which would warrant the procedure. As to the consent required see also VanMeter v. Crews, 149 Ky. 335, 148 S.W. 40 (1912).
From this table it may be seen that there is certainly no indication of an increase in malpractice litigation in Kentucky at the appellate level. If anything, there appears to be a slight decrease since in the past decade only five malpractice cases have reached the Court of Appeals.

Having performed a cursory examination of the material available on the subject of medical malpractice in Kentucky, let us proceed to examine some of the cases in detail in order to arrive at a working knowledge of the state of the law of medical malpractice in Kentucky today. In so doing, it is important to keep in mind that negligence on the part of a physician in treating the patient may occur at any of three stages: 1) at the primary stage which will be referred to as the diagnostic stage, 2) at the treatment or operative stage, 3) and in postoperative care. Of course the physician may be negligent at any two or at all three of these stages.

**Negligence at the Diagnostic Stage**

A physician may be liable for failing to use reasonable care and skill in discovering the patient's malady.\(^{11}\) Where the doctor is negligent in his diagnosis, such negligence often leads to the giving of improper treatment which may also be negligent. The failure to give a proper examination, upon which to base a diagnosis, may constitute negligence. Thus, where a physician diagnosed the patient's illness as kidney trouble without giving her an examination, when she was in fact pregnant, and the medicine prescribed caused her child to be born dead, whether the failure to examine constituted negligence presented a jury question.\(^{12}\) Similarly, negligence was proved where the physician diagnosed the patient's illness as an ulcer in the womb when she was pregnant and his treatment caused an abortion.\(^{13}\) The failure to discover pre-existing conditions which would make the type of medication administered toxic also constitutes negligence. Thus, where the patient had rheumatic fever and had just recovered from the flu, the physician was held liable for giving only a cursory

\(^{11}\) Van Sant's Adm'r v. Overstreet, 261 Ky. 58, 86 S.W.2d 1008 (1935).


\(^{13}\) Acton v. Smith, 150 Ky. 703, 150 S.W. 854 (1912).
examination before administering an anesthetic which caused the patient's death during a tonsillectomy.\textsuperscript{14}

A good illustration of the extent to which liability may be imposed upon the physician for failing to properly examine and consider all the factors which might cause additional injury to the patient is shown in the early case of \textit{Baute v. Haynes}.\textsuperscript{15} The patient had broken her arm and her parents had applied cold spring water packs to the arm. Twenty-four hours later the defendant set the broken arm. He did not treat the patient further and the arm subsequently had to be amputated. There was evidence that the bandage had been applied too tight so that circulation was stopped. There was also evidence that infection had been caused by bacteria in the cold spring water. The court held that even if the cold spring water had caused the infection, this did not relieve the defendant of liability since he knew of the kind and duration of the treatment given, and he should have used reasonable care and skill to determine whether or not the arm was infected and if so, to treat the infection. While one may speculate as to whether the court would have been so emphatic if there had not been evidence of the bandage having been too tight, yet this case seems to make the physician an insurer that when he undertakes to treat an apparent condition he will also discover any other condition from which the patient might suffer injury. It is submitted that such a standard is one which would be impossible for the medical profession to live up to and that it imposes liability in such cases as a matter of course.

A physician may be liable for failing to use x-rays in aiding him to make a proper diagnosis. Such was the case in \textit{Hoover v. McCormick},\textsuperscript{16} where the defendant failed to properly diagnose the patient's dislocated elbow and a proper reduction was, therefore, not made. The court held that it was a jury question as to whether reasonable care and skill would have dictated that x-rays be taken.

Delay in the diagnosis may also impose liability upon the physician. A verdict for the plaintiff was affirmed where the physician delayed in diagnosing gangrene in the plaintiff's foot so that an amputation was made necessary.\textsuperscript{17}

We see from these cases that in Kentucky, while the limits of liability for negligence in the diagnosis of the patient's illness have not been clearly set, such liability will definitely be imposed under certain factual situations. The care and skill which the law requires

\textsuperscript{14} Van Sant's Adm'r v. Overstreet, 261 Ky. 58, 86 S.W.2d 1008 (1935).
\textsuperscript{15} 31 Ky. L. Rep. 876, 104 S.W. 272 (1907).
\textsuperscript{16} 197 Ky. 509, 247 S.W. 718 (1923).
\textsuperscript{17} Williams v. Nally, 20 Ky. L. Rep. 244, 45 S.W. 874 (1898).
the physician to utilize in diagnosing a disease will probably become more stringent in the future as medical science discovers new and better techniques for use in diagnosing an illness. The advent of the use of the x-ray to aid in diagnosing bone injuries set a new standard of care as we saw in the Hoover case. The physician is no longer safe in making an intuitive diagnosis after a cursory examination. In the diagnostic area, the law has kept up with medical science and its techniques to a surprising degree. We have here an almost ideal balance between the standards which the law requires and those which are recognized as the best by the medical profession. The law must continue to maintain this delicate balance and it must continue to keep itself informed of the standards required by the medical profession and the techniques available, if it is to continue to serve its purpose of enforcing the best medical standards available under the circumstances upon the medical practitioner and thereby better preserving the safety of the society which it is designed to serve.

Negligence at the Treatment Stage

It is at the stage of treatment that most negligence occurs which becomes the basis of malpractice suits. This is the main stage in medical practice for it is at this stage that the greatest amount of medical knowledge is utilized by the practitioner. It is not surprising then, that the treatment (or operative stage) stage involves the largest number of patient complaints. Furthermore, as we have seen, the treatment may be incorrect or negligent because of the prior negligence in the diagnosis. Thus, while the treatment itself was administered correctly it may still constitute malpractice because it was given upon an erroneous diagnosis. However, a physician is not responsible for the erroneous exercise of his professional judgment, provided he informs himself of the facts by a proper examination.\(^{18}\) Neither will a physician's negligence be presumed from poor results, his failure to effect a cure,\(^ {19}\) nor from the effect his medicine has on the patient.\(^ {20}\)

If a physician properly diagnoses a case and he knows that he is not equipped or trained to treat the disease, then the physician may be under a duty to apprise the patient of this fact so that he may obtain skilled help. In Burk v. Foster\(^ {21}\) the court pointed out that the mere fact that the result of the patient's treatment is as good as is usually obtained in like cases similarly situated will not preclude a

\(^{18}\) Meador v. Arnold, 264 Ky. 378, 94 S.W.2d 626 (1936).
\(^{19}\) Rose v. Sprague, 248 Ky. 635, 59 S.W.2d 554 (1933).
\(^{20}\) Prewitt v. Higgins, 231 Ky. 678, 22 S.W.2d 115 (1929).
\(^{21}\) 114 Ky. 20, 69 S.W. 1098 (1902).
recovery by the patient against the physician for negligence and lack of skill, as the patient is entitled to the chance for better results which might come from proper treatment. It is the right of the patient to be apprised of his condition and that the physician is not properly equipped to handle it so that he can obtain more skilled attention if he so desires.

The standard of care and skill required in the treatment or operative stage is not that of the best skill and ability of the individual physician, which would be a subjective standard, but that of the care and skill which is exercised generally by physicians of ordinary care and skill in similar communities in like cases. Generally, the facts necessary to establish a cause of action for negligence against a physician can only be proved by experts skilled in medicine or surgery. The right of recovery can only be established by the testimony of laymen where the subject matter is within the common knowledge of laymen or ascertainable by the nonexperts' senses. In malpractice cases as in other negligence cases, the plaintiff must not only prove the negligence, but he must also prove that it was the proximate cause of the injury complained of. The law presumes that the physician properly performed his duties and the burden of proof is on the plaintiff to prove otherwise. A poor result will not shift this burden of proof.

In cases which involve the setting of bones, there seems to be some conflict as to the proof required to establish negligence in the treatment or operation. These cases usually involve limbs which heal crooked. Thus, in an early case, where negligence was alleged in the setting of plaintiff's dislocated shoulder so that the condition did not improve, a verdict for the plaintiff was reversed for error in the court's instructions to the jury as to want of skill, lack of education,

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22 Dorris v. Warford, 124 Ky. 768, 100 S.W. 312 (1907). Dentists are subject to the same standard as doctors in performing their services. See Tanner v. Sanders, 247 Ky. 90, 56 S.W.2d 718 (1933).

23 Stacy v. Williams, 253 Ky. 353, 69 S.W.2d 697 (1934); Walden v. Jones, 289 Ky. 395, 158 S.W.2d 609 (1942).

24 Ibid. See also Neal v. Wilmuth, 342 S.W.2d 701 (Ky. 1961), where the dentist's drill slipped and the dentist was off balance and fell, burying the drill in the patient's mouth. The court said that ordinary professional skill should require him to maintain his balance in such a way that if the drill does happen to slip he will not lose his footing and bury the instrument in the soft tissues of the patient's mouth since it is known that drills frequently do slip.

25 Powell v. Galloway, 229 Ky. 37, 16 S.W.2d 489 (1929). Without proof of negligence there can be no proof of proximate cause. See Kirby's Adm'r v. Berea College, 196 Ky. 353, 244 S.W. 775 (1922); Hazard Hospital v. Combs' Adm'r, 263 Ky. 252, 92 S.W.2d 35 (1938); Fields v. Rutledge, 284 S.W.2d 659 (Ky. 1955).

26 Hanners v. Salmon, 216 Ky. 584, 285 S.W. 307 (1926).

and ignorance since such could not be the basis of the negligence complained of in producing the injury. But in a later case\textsuperscript{28} where there was no evidence of whether the treatment was proper, whether there was a lack of skill, or the standard of care required, it was held that a directed verdict for the defendant was improper since the broken foot and ankle which he set had healed crookedly and this was evidence of negligence. While no mention was made of res ipsa loquitur, this case seems to apply a silent doctrine of res ipsa loquitur.

In an amputation case,\textsuperscript{29} negligence was shown by the mere fact that the bones were cut unevenly so that the stump failed to heal properly. Two other cases\textsuperscript{30} held that the fact that a broken arm healed crookedly was sufficient evidence of negligence to allow the case to be submitted to the jury.

The law imposes certain specific duties upon specialists in medical practice and holds them responsible for a breach of that duty notwithstanding a contrary practice by the physicians themselves. The best known of these duties is the duty of the surgeon to see that everything which goes into a patient during surgery is removed. The best known of these devices is the notorious sponge. The necessities of surgical practice require that the operating room nurse be responsible for counting the sponges and ascertaining that they are all present and accounted for before the wound is closed. Despite the medical necessities, the law in Kentucky says that it is the surgeon’s duty to see that all sponges and gauzes are removed from the wound.\textsuperscript{31} But if the wound is closed and it is discovered that a sponge was left therein, then it is the surgeon’s duty to open the wound and find the sponge as soon as possible if such will not endanger the patient’s life.\textsuperscript{32} Even if surgeons testify that the best of them sometimes leave sponges in patients in similar operations, this is no excuse says the law, since the fact that all men are sometimes careless does not relieve one man from the consequences of his careless act.\textsuperscript{33}

In the sponge cases as in all other cases, the plaintiff must prove that the negligence in leaving the sponge inside him was the proximate cause of his injury. Thus, in Mason v. Meloan\textsuperscript{34} it was held that the defendants were entitled to a new trial on the ground of newly discovered evidence tending to show that the goiter upon which

\textsuperscript{28} Hickerson v. Neely, 21 Ky. L. Rep. 1257, 54 S.W. 842 (1900).
\textsuperscript{29} Alexander v. Menefee, 23 Ky. L. Rep. 1151, 64 S.W. 855 (1901).
\textsuperscript{30} Leadingham v. Hillman, 224 Ky. 177, 5 S.W.2d 1044 (1928); Knopp v. Thornton, 199 Ky. 216, 250 S.W. 553 (1923).
\textsuperscript{31} Barnett’s Adm’t v. Brand, 165 Ky. 616, 177 S.W. 461 (1915).
\textsuperscript{32} Ibid.
\textsuperscript{33} Samuels v. Willis, 133 Ky. 459, 118 S.W. 339 (1909).
\textsuperscript{34} 165 Ky. 532, 177 S.W. 495 (1915).
they operated unsuccessfully was malignant, which prevented the wound from healing, rather than the gauze which had been left in it for fifteen days.

Sponges are not the only articles left in patients in Kentucky. A rubber tube left in the lung after treatment for pneumonia which caused the lung to hemorrhage twenty years later and necessitated removal of the lung drove one patient to the courts to seek restitution. He was allowed recovery twenty years later since he relied on the defendant's statement that no harm would result as the tube would be taken up by the blood and absorbed into the body. In this instance, the patient suffered harm. Recovery was denied, however, where surgeons left gauze in the patient's vagina for two weeks, as no injury resulted. Recovery was also denied where two needles broke off in the patient's foot during surgery to repair an artery which was severed. There was evidence that the patient "went bad" on the operating table and that it was necessary to hurry the procedure. There was also testimony that the danger of infection would have been increased if further attempts were made to find the needles. The court held that res ipsa loquitur was inapplicable as the presence of infection alone could not be evidence of negligence following surgery. This seems to be in accord with the general rule that where the evidence fails to establish that the mistreatment is the cause of the injury in such a manner that it could not be said to be equally likely to be caused from some other source a directed verdict is in order.

A physician may not be liable only for his own negligence in treating a patient, he may also be liable for the negligence of a fellow physician when they are working on the same case. In Beauchamp v. Davis the court pointed out that while two physicians engaged to treat the same patient concurrently may make such division of services as the circumstances may require, each in serving with the other is liable not only for his own negligence, but also for any wrongful act or omission of the other which he observed and permitted to continue without objection, or which, in the exercise of reasonable diligence, he should have observed.

We see from these cases the broad liability which may attach to the physician in the treatment or operative stage. Each case seems to

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35 Adams v. Ison, 249 S.W.2d 791 (Ky. 1952).
36 Ibid.
38 Steinmetz v. Humphrey, 289 Ky. 709, 160 S.W.2d 6 (1942).
39 Cochran's Adm'r v. Krause, 144 Ky. 202, 137 S.W. 1053 (1911); Adkins v. May, 216 Ky. 785, 238 S.W. 785 (1926).
40 309 Ky. 397, 217 S.W.2d 822 (1948).
turn on its own peculiar factual situation. What constitutes malpractice is not altogether clear, nor is it clear what proof will be required in any given instance. However, it is safe to conclude that with laymen increasing their understanding of how medical science operates and what may be expected of it, less proof will be required in the future. There has been no flood of malpractice litigation in Kentucky, as of this time, which would establish any discernible trend as to the outer limits of medical liability in the treatment stage. Perhaps, we may well hope that there will not be.

Negligence at the Postoperative Stage

A physician is under no legal duty to undertake to treat a patient; but having once undertaken to do so, he must continue to do so as long as necessary. The relationship is contractual and may be terminated by consent. But a physician must not leave a patient without making arrangements calculated to obtain favorable results.

In cases where the cause of action alleged is that the physician failed to attend to the patient after surgery, the plaintiff must prove that the physician had an obligation to do so, that he failed to comply therewith, and that such failure caused injury to the plaintiff. He need not prove that another doctor was unavailable and could not be obtained since it is the defendant's duty to care for the patient.

Just as at any other stage, at the postoperative stage the plaintiff must prove that the defendant's neglect was the proximate cause of the injury complained of. This is well-illustrated in the case of Elam's Adm'r v. Botkin. The defendant in that case operated upon the plaintiff and removed his tonsils. He checked on the plaintiff later in the day and then left town. The patient was later moved to a hospital where he died. The court upheld a directed verdict for the defendant pointing out that although there may have been negligence in leaving the patient when he did, there was no proof that such was the proximate cause of the patient's death. The plaintiff failed to prove that death would probably not have resulted had the defendant made provision for the patient's care and treatment before leaving town.

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41 See Miller v. Blackburn, 170 Ky. 263, 185 S.W. 864 (1916). It is the duty of a physician to exercise both care and skill in the discontinuance of his services as well as in the performance of them, but the relationship is contractual, the duties are implied from the contract and the relationship may be terminated by assent, after which no implied duty can attach.
42 Williams v. Tarter, 286 Ky. 717, 151 S.W.2d 783 (1948).
44 Ibid.
45 227 Ky. 517, 13 S.W.2d 507 (1929).
It is in the postoperative stage that the Court of Appeals has seemed to be most willing to apply the doctrine of res ipsa loquitur. The doctrine was applied as early as 1930 in the case of Quillen v. Skaggs. The defendant was a surgeon and the proprietor of a small hospital. The plaintiff, while under an anesthetic, was placed in a bed with a hot water bottle which caused severe burns. The court held that the doctrine of res ipsa loquitur applied and that the application of the doctrine made a prima facie case for the plaintiff, so far as negligence was concerned, by merely shifting the burden of producing evidence upon the subject to the defendant. The presumption is rebuttable and means no more than that the plaintiff is entitled to a favorable finding unless the defendant produces evidence to overcome it. The court emphasized that the management and control of the agency which produced the injury was exclusively vested in the defendant and that the plaintiff was not in a position to show the particular circumstances which caused the instrumentality to operate to his injury. The defendant, being more favorable situated and having the superior knowledge or means of information as to what caused the accident, has the burden of going forward with the explanation.

The doctrine of res ipsa loquitur is closely connected with the requirement of expert testimony in medical malpractice cases. When the doctrine is invoked, expert testimony is often dispensed with. One of the most interesting and affirmative cases ever to be decided by the Court of Appeals in this connection is that of Butts v. Watts. The facts are simple. The defendant, a dentist, left a piece of a tooth in the plaintiff's jawbone while extracting a tooth. This fragment was easily discovered by another dentist by the use of an x-ray. The action was for pain and suffering caused by the defendant's postoperative negligence in refusing to use an x-ray or otherwise seeking to discover the cause of the plaintiff's pain. The court held that the bare fact that the defendant refused to seek to discover the cause of the pain when it was ascertainable by a simple procedure was sufficient to take the case to the jury. The court pointed out that it was within the common knowledge of laymen that to leave a fragment of a tooth in a socket and then refuse to attempt to discover what caused the suffering, constituted negligence. The court said that res ipsa loquitur applies, just as in the sponge cases. It said further:

> The rule that expert testimony is indispensable ought not to be too strictly applied, although ordinary laymen are not qualified to say that a

46 233 Ky. 171, 25 S.W.2d 33 (1930).
47 290 S.W.2d 777 (1956).
doctor was negligent or was not negligent. But the notorious unwillingness of members of the medical profession to testify against one another may impose an insuperable handicap upon a plaintiff who cannot obtain professional proof.48

In this statement we see judicial recognition of the so-called “conspiracy of silence” of the medical profession in malpractice cases. It appears that the Court of Appeals may have undertaken a policy of applying the doctrine of res ipsa loquitur in order to overcome the conspiracy of silence. This seems to be an adaptation of the policy followed in California.49 Such a policy is open to much criticism. It would seem that instead of distorting the doctrine of res ipsa loquitur to allow the plaintiff recovery without expert testimony, it would be more consistent with established legal theory to modify directly the rule which requires expert testimony.

Conclusion

We have seen the close relationship between the three stages at which medical negligence may occur. There are no cut and dried cases in Kentucky. Occasionally legal theory has been distorted in an obvious attempt to either allow recovery or deny it. Whether this is good or bad is a value judgment and not the subject of the inquiry of this paper. However, it appears that the field of medical malpractice is becoming a field of negligence in its own right and that more definite specialized rules need to be formulated as in other specialized fields of negligence such as the common carrier cases.

There is a great need for closer inter-professional understanding between the medical and legal professions concerning the problems involved in medical malpractice actions. The medical profession needs to understand that because a doctor is found negligent does not mean that he is not a competent physician any more than that because a person is found negligent in an automobile accident means that he is incompetent to drive a car. It only means that at one given point in time he failed to use the proper standard of care. On the other hand, the legal profession needs to understand its responsibility to society to make sure that a malpractice action is justified before it is brought.

The fact is simple. A physician who is sued for malpractice,

48 Id. at 779.
49 See Ybarra v. Spanguard, 154 P.2d 687 (Cal. 1944). With this case the highest appellate court of California began a policy of applying res ipsa loquitur in almost any situation where the patient could not get sufficient proof to show the circumstances of his injury. The net effect was to put the burden of proof on the defendant to show not only the absence of negligence, but also the circumstances surrounding the accident.
whether found to be at fault or not, is often irreparably harmed in his career due to the publicity in his community of the suit and due to the tendency of the public to feel that a suit would not have been brought had there not been a justifiable claim. The public tends to feel that because a doctor is sued, he is incompetent to practice medicine. This may be true in a few instances, but it is not true of the majority of doctors who are sued for malpractice.

Similarly, a person injured by a physician's negligence should not be thwarted in his effort to obtain expert testimony. As long as the medical profession has a defensive attitude however, he will be. Once the medical profession obtains faith in the integrity of the legal profession, the conspiracy of silence will be reduced. The problem of medical malpractice is a double-edged sword. It cuts both ways.

A possible solution to the problem which is certainly worth active investigation is that of the expert board. Such a board would be composed of experts in the various medical specialties and of lawyers. A malpractice claim could be informally heard before this board in a private, non-publicized proceeding. Either of the parties would then have the right to appeal to the courts for relief if genuinely convinced that the decision was unfair. It is submitted that such a possibility is worthy of speedy and serious investigation by the Kentucky State Bar Association. The doctor-patient relationship should not be further jeopardized by having every doctor thinking that every patient he sees is a potential malpractice suit.

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