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A REAPPRAISAL OF LIABILITY FOR UNAUTHORIZED MEDICAL TREATMENT*

ALLAN H. McCoid**

INTRODUCTION

In March, 1904, Anna Mohr had an earache. From such an inauspicious beginning grew a law suit which was to cost one doctor $14,322.50,¹ and to establish a precedent for the liability of any doctor who went beyond the limits of the explicit consent of his patient in rendering medical treatment.

"Malpractice" on the part of doctors² has been defined in various terms:

Any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct . . . professional misconduct towards a patient which is considered reprehensible either because immoral in itself or because contrary to law or expressly forbidden by law . . . bad, wrong, or injudicious treatment of a patient, professionally and in respect to the particular disease or injury, resulting in injury, unnecessary suffering, or death to the patient, and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rules or principles, neglect, or malicious or criminal intent.³

³ the wrongful or improper practice of medicine, which results in injury to the patient.⁴

. . . the failure upon the part of a physician or dentist properly to perform the duty which devolves upon him in his professional

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*The author wishes to express his appreciation for the comments of Dr. Albert Mowlem and Dr. Russell Eilers of the University of Minnesota Hospitals in connection with this study. At the same time, he wishes to state that the conclusions, and any medical errors, are entirely his own.

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1. Mohr v. Williams, 95 Minn. 261, 104 N.W 12 (1905).
2. Because the various cases of unauthorized medical treatment and malpractice involve physicians, surgeons, dentists, chiropractors, and osteopaths, the term "doctor" is used to cover anyone who may be classified as legally entitled to practice in any branch of the healing arts. While this may not be technically correct in all cases, the author believes that this generalized term may be used in such a study.
relation to his patient, a failure which results in some injury to the patient.\textsuperscript{5}

The treatment of a case by a surgeon or physician in a manner contrary to accepted rules and with injurious results to the patient, hence, any professional misconduct or any unreasonable lack of skill or fidelity in the performance of professional or fiduciary duties.\textsuperscript{6}

Most frequently, however, medical malpractice is thought of in terms of the failure of a physician, surgeon or dentist to comply with the standard of conduct established by the reasonable and ordinary practice of doctors of the same system or school of practice and in the same general locality as the doctor under consideration.\textsuperscript{7} So defined, malpractice appears to be only a specialized form of negligence, substituting for the “reasonable and prudent man” the hypothetical individual who might be called “the reasonable and competent doctor,” and requiring that the standard of care or deviation

\textsuperscript{5} Regan, Doctor and Patient and the Law 17 (3d ed. 1956).

\textsuperscript{6} Merriam-Webster New International Dictionary (2d ed. 1953).

\textsuperscript{7} See, e.g., Napier v. Greenzweig, 256 Fed. 196, 197 (2d Cir. 1919) "The law is well established that a surgeon or physician attending a patient is bound by his contract to possess and to give the case such reasonable and ordinary skill and diligence as surgeons and physicians in similar localities and in the same general line of practice ordinarily exercise in like cases." Sinz v. Owens, 33 Cal.2d 749, 753, 205 P.2d 3, 5 (1949) "The standard against which the acts of a physician are to be measured is not the highest skill medical science knows; the law exacts of physicians and surgeons in the practice of their profession only that they possess and exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances." Adkins v. Ropp, 105 Ind. App. 331, 334, 14 N.E.2d 727, 728 (1938) "When a physician and surgeon assumes to treat and care for a patient, in the absence of a special agreement, he is held in law to have impliedly contracted that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skill, diligence and care in his treatment of him. In determining whether the physician or surgeon has exercised the degree of care and skill which the law requires, regard must be had to the advanced state of the profession at the time of treatment and in the locality in which the physician or surgeon practices." Nelson v. Nicollet Clinic, 201 Minn. 505, 509, 276 N.W. 801, 803 (1937) "A physician or surgeon is only required to possess and exercise the degree of skill and learning ordinarily possessed by members of his school of the profession in good standing and to apply that skill and learning with reasonable care and diligence and his best judgment." Loudon v. Scott, 58 Mont. 645, 654, 194 Pac. 488, 491 (1920) "[The physician] assumes toward the patient the obligation to exercise such reasonable care and skill as is usually exercised by physicians or surgeons of good standing, of the same system or school of practice in the community in which he resides, having due regard to the condition of medical and surgical science at that time." Prosser, Torts 133 (2d ed. 1955), 41 Am. Jur., Physicians and Surgeons § 82 (1942) Some jurisdictions do not place controlling weight on the locality, particularly where communication of new developments and access to modern facilities are available without undue burden on the doctor. See, e.g., Sinz v. Owens, supra. Villa v. Fleming, 132 Minn. 128, 155 N.W. 1077 (1916), Prosser, Torts 134 (2d ed. 1955).
therefrom be established through the use of expert witnesses\(^8\) except in the most extreme cases.\(^9\) It is this form of malpractice which most frequently occupies the courts' time in litigation between patient and doctor; and it is undoubtedly this form of malpractice claim against which most doctors seek to protect themselves by resort to malpractice insurance.

Somewhat removed from this general area of "negligent malpractice" lies a group of cases which appear on first glance to involve something more than a mere unintentional deviation from a general standard of care. The most familiar example of this type of malpractice is the case of an unauthorized operation, \(^i.e.,\) an operation performed without the consent of the patient. Courts dealing with this type of unauthorized medical treatment frequently speak in terms of "assault and battery."\(^10\)

The classification of the claim as one for "assault and battery" has many possible effects. In contrast to the requirement in negligent malpractice cases that medical experts be used to establish the basic standard of conduct or deviation therefrom,\(^11\) the plaintiff in an assault and battery action may rely entirely on non-expert testi-


\(^9\) Where the alleged negligence involves such misconduct as leaving a sponge in the patient's body, Laughlin v. Christensen, 1 F.2d 215 (8th Cir. 1924); Funk v. Bonham, 204 Ind. 170, 183 N.E. 312 (1932); Fredrickson v. Maw, 119, Utah 385, 227 P.2d 717 (1951); or removing the wrong tooth, Ambrosi v. Mons, 85 A.2d 188 (D.C. Mun. App. 1951); Steinke v. Bell, 32 N.J. Super. 67, 107 A.2d 825 (1954), or a badly set arm, McMillen v. Foncannon, 127 Kan. 573, 274 Pac. 237 (1929), the courts are likely to say that the question is one upon which even non-expert testimony is sufficient.


\(^11\) See notes 8 and 9 supra.
mony, particularly his own. In a battery action there is no need to show any actual physical injury, the mere invasion of the plaintiff’s right to be free from unwarranted touching being sufficient to establish damages. It is also more likely that the defendant in a battery action will be subjected to exemplary or punitive damages than if the action is one for negligence. On the other hand, the plaintiff whose case is characterized as one for battery may find himself subjected to a much shorter period of limitations than is applied to an action for negligent malpractice, or may find that he is unable to bring an action against the federal government under the Federal Tort Claims Act for injuries incurred in a veterans’ hospital.

There is even some suggestion that if the claim is made for an unauthorized operation it is so inconsistent with a claim for negligence that the two may not be maintained in the same action. But the most significant factor to the doctor is likely to be that as defendant in a battery action, he will be unable to rely upon expert testimony that he has in fact complied with the standard of care normally exercised by reasonable physicians. It should be noted,

12. See Prosser, Torts 31-32 (2d ed. 1955), Restatement, Torts § 18 (1934). Although it is usual for the plaintiff in these actions to allege and recover for “pain and suffering,” there is no particular attempt in most of the cases to differentiate between the pain and suffering incident to the original condition and that which is solely the result of the unauthorized treatment. But cf. Paulsen v. Gundersen, 218 Wis. 578, 260 N.W. 448 (1935). Nominal damages are allowed in the unauthorized operation cases. See Church v. Adler, 350 Ill. App. 471, 483, 113 N.E.2d 327, 332 (1953), Butler v. Molinski, 198 Tenn. 124, 131, 277 S.W.2d 448, 451 (1955).


15. 28 U.S.C. § 2680 (1952) specifically exempts from the provisions of the Federal Tort Claims Act “any claim arising out of assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, misrepresentation, deceit, or interference with contract rights.” This has been applied to an unauthorized operation in Moos v. United States, 118 F. Supp. 275 (D.Minn. 1954), aff’d, 225 F.2d 705 (8th Cir. 1955).


however, that in many cases where there has in fact been no authorization for the medical treatment, the courts have not followed a strict "battery" theory and have sometimes spoken of the case as not distinguishable from other forms of malpractice.\(^{18}\)

The present study deals with the unauthorized medical treatment form of malpractice. The basic inquiry is whether there is a real distinction between "negligent" malpractice and unauthorized treatment or whether the same standard of conduct may be applied in all cases involving improper action on the part of doctors. The older decisions described and analyzed in this study have been classified in other discussions dealing with the necessity for consent to an operation.\(^{19}\) The present study will place little emphasis on the question of whose consent is necessary, although it should be noted that when the patient is a minor\(^{20}\) or mentally incapacitated\(^{21}\) the


20. The general rule is that the consent of the parent is necessary in order to operate on a minor, Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941) (15 year old boy submitted to serious plastic surgery); Rogers v. Sells, 178 Okla. 103, 61 P.2d 1018 (1936) (14 year old's foot amputated after auto accident); Moss v. Rishworth, 222 S.W. 228 (Tex. Comm'n App. 1929) (11 year old died under anaesthetic in preparation for removal of tonsils and adenoids). Restatement, Torts § 59 (1934). Cf. Perry v. Hodgson, 168 Ga. 678, 148 S.E. 659 (1929) (18 year old submits to operation on leg after agreement between doctor and father). However, the doctor has been allowed to operate with only the minor's consent where the minor is capable of understanding the nature of the operation and the risk involved. Bishop v. Shurly, 237 Mich. 76, 211 N.W. 75 (1926) (19 year old consented to removal of tonsils and administration of local anaesthetic from which he died); Bakker v. Welsh, 144 Mich. 632, 108 N.W. 94, 7 L.R.A. (n.s.) 612 (1906) (17 year old consented to removal of tumor and administration of anaesthetic under which he died); Gulf & S.I. R.R. v. Sullivan, 155 Ala. 1, 119 So. 501, 62 A.L.R. 191 (1928) (17 year old consented to vaccination); Lacey v. Laird, 139 N.E.2d 25 (Ohio 1956) (18 year old consented to plastic surgery on nose), Restatement, Torts § 59 (1934). Or if the circumstances create an emergency in which immediate treatment is necessary and the consent of the parent is impracticable to obtain, the doctor may operate or render medical assistance. Jackovach v. Yocum, 212 Iowa 914, 237 N.W. 444, 76 A.L.R. 551 (1931) (minor fell from train, had long scalp wound, two or three inches in length, was bleeding profusely, had crushed elbow joint, and compound, comminuted fracture; arm amputated after consultation of doctors); Wells v. McGehee, 39 So.2d 196 (La. App. 1949) (child had broken arm, effort made to call mother at place of work before administering anaesthetic, under which child died); Luka v. Lowrie, 171 Mich. 122, 136 N.W. 1106, 41 L.R.A. (n.s.) 290 (1912) (child knocked down by train and thrown under wheels resulting in crushing of left foot, compound disarticulation of bones of foot, with principal bones torn away and flesh crushed and torn from top of foot leaving muscles, ligaments and bone exposed; child unconscious with weak pulse and foot cold
consent of a parent or guardian may be necessary. On the other hand, if the patient is unconscious or otherwise incapable of understanding the situation or of communicating consent to treatment in the particular situation, the consent of a spouse or some other duly authorized representative may be sufficient to protect the physician or surgeon rendering medical treatment. There may also be question as to whether the consent of the patient's spouse is required where the operation or treatment will have the effect of interfering with conjugal rights or privileges. The major divisions of

and dead before foot amputated), Sullivan v. Montgomery, 155 Misc. 448, 279 N.Y. Supp. 575 (N.Y. City Ct. Bronx Co. 1935) (20 year old's foot or ankle injured and set without father's knowledge), Ollet Pittsburgh, C.C. & St. L. Ry., 201 Pa. 361, 50 Atl. 1010 (1902) (17 year old's foot crushed in railroad accident; he was taken to doctor against his will). There is some basis for arguing that where the parent refused to grant consent, the courts may make it possible to give medical treatment on the ground that the child is neglected. See People ex rel. Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769 (1952), cert. denied, 344 U.S. 824 (1952), In re Seiferth, 225 App. Div. 221, 137 N.Y.S.2d 35 (4th Dep't 1955), In re Vasko, 238 App. Div. 128, 263 N.Y. Supp. 552 (2nd Dep't 1933). Smith, Antecedent Grounds of Liability in the Practice of Surgery, 14 Rocky Mt. L. Rev. 233, 247 (1942) But see In re Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942), where there was no statutory provision.


23. See Smith, Antecedent Grounds of Liability in the Practice of Surgery, 14 Rocky Mt. L. Rev. 233, 248 (1942), Restatement, Torts § 59 (1934) In Mohr v. Williams, 95 Minn. 261, 104 N.W 12, 1 L.R.A. (n.s.) 439 (1905), the defendant argued that the presence of the patient's family physician in the operating room and his apparent acquiescence in the operation should satisfy this theory of consent, but the court said, "It is not disputed but that the family physician of plaintiff was present on the occasion of the operation, and at her request. But the purpose of his presence was not that he might participate in the operation, nor does it appear that he was authorized to consent to any change in the one originally proposed to be made. Plaintiff was naturally nervous and fearful of the consequences of being placed under the influence of anaesthetics, and the presence of her family physician was required under the impression that it would allay and calm her fears. The evidence made the question one of fact for the jury to determine." While in Bennan v. Parsonnet, 93 N.J.L. (54 Vroom) 20, 83 Atl. 948 (1912), the court reasoned that in view of the fact that the patient was unconscious and therefore incapable of giving consent during the operation, it was imperative that some representative be able to act, "to represent him in those matters affecting his welfare concerning which he cannot act for himself. The surgeon whom the patient himself has selected alone fills all of these requirements, and hence upon him the law should cast the responsibilities of this office by the legal implication that the patient intended him to act for him when he had made no other selection." In Keister v. O'Neil, 59 Cal. App. 2d 428, 138 P.2d 723 (1943), the consent of the plaintiff's mother-in-law was conceded to be binding upon the plaintiff, probably because both the plaintiff and her husband were minors.

24. See Smith, Antecedent Grounds of Liability in the Practice of Surgery, 14 Rocky Mt. L. Rev. 233, 280-84 (1942) It is fairly clear that there is normally no necessity for a spouse to consent where the patient
the present study are: (a) The development of the traditional statement of the law as to a doctor's liability for unauthorized medical treatment, (b) an analysis of the cases involving such unauthorized treatment in terms of the conduct of the doctor and its consequences, and (c) an evaluation of the variations found in the cases in terms of how the law may best give adequate protection to both the patient and the doctor.

**General Background**

The American law regarding civil liability for unauthorized medical treatment seems to have had its formulation in four cases decided in four different jurisdictions shortly after the beginning of this century:25 *Mohr v. Williams,*26 *Pratt v. Davis,*27 *Rolater v. Strain,*28 and *Schoendorff v. Society of New York Hospital.*29

Anna Mohr consulted Dr. Williams, a specialist in disorders of

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25. These are not the earliest cases in which a doctor was charged with having performed an operation without the consent of the patient. The earliest reported case appears to be *Slater v. Baker & Stapleton*, 2 Wils. K.B. 359, 95 Eng. Rep. 860 (1767), but the court there treated the action of the two "surgeons" in rebreaking the patient's broken and improperly mended leg more as negligent conduct than as an assault. Some earlier American decisions, such as *State to the Use of Janney v. Housekeeper*, 70 Md. 162, 16 Atl. 382, 2 L.R.A. 587 (1889), *McClallen v. Adams*, 19 Pick. 333, 31 Am. Dec. 140 (Mass. 1837), *Carstens v. Hanselman*, 61 Mich. 426, 28 N.W. 159 (1886). There have been several recent cases in which the spouse has been granted a right of recovery for loss of consortium. See *Hitaffer v. Argonne Co.*, 183 F.2d 811 (D.C. Cir. 1950) (wife recovers); *Gist v. French*, 136 Cal. App. 2d 247, 288 P.2d 1003 (1955) (husband recovers for injuries done to wife by series of operations); *Aucuff v. Schmit*, 78 N.W.2d 480 (Iowa 1956) (wife recovers for negligent injury to husband). *But cf.* *Rosenberg v. Feigin*, 119 Cal. App. 2d 783, 260 P.2d 143 (1953) (husband not allowed to recover for induction of miscarriage); *Hartman v. Cold Spring Granite Co.*, 247 Minn. 515, 77 N.W.2d 641 (1956) (expressing doubt as to the *Hitaffer* doctrine, although barring recovery by wife on basis of Workmen's Compensation Act); *Nickel v. Hardware Mutual Casualty Co.*, 269 Wis. 647, 70 N.W.2d 205 (1955) (denying wife's recovery for loss of consortium). The author of the note in 14 U. Cin. L. Rev. 161, 170-72, 180 (1940), concluded that the consent of the spouse was not necessary, but noted that if the patient had a cause of action the spouse might also have a cause of action for damages for infringement of right of consortium and loss of services.

26. 95 Minn. 261, 104 N.W. 12, 1 L.R.A. (n.s.) 439 (1905).
27. 224 Ill. 300, 79 N.E. 562, 7 L.R.A. (n.s.) 609 (1905).
29. 211 N.Y. 125, 105 N.E. 92 (1914).
the ear, complaining of trouble in her right ear. Dr. Williams examined both her ears, but was unable to make a complete diagnosis of the left ear due to foreign substances in it. He concluded on the basis of the examination that the bones of the right ear were diseased and advised an operation, to which the patient consented. Upon closer examination, under anaesthetic, the doctor discovered that the condition of the right ear was not so serious, but that the left ear was seriously diseased. He operated on the left ear. Mrs. Mohr sued, claiming that the operation impaired greatly the hearing in the left ear. In spite of evidence that the operation was skillfully performed and that it was probably beneficial, the court held that the operation on the left ear was not authorized and constituted an assault and battery. The court based its decision upon "the right of inviolability of [her] person [which] necessarily forbids a physician or surgeon, however skillful or eminent, to violate without permission the bodily integrity of his patient by a major or capital operation." At the same time, the court recognized that there might be instances in which a doctor should be permitted to operate without the express consent of the patient. The most obvious of these was the situation in which the patient was unconscious and his injuries required immediate surgical or medical attention. In such a case, the court said, the doctor might proceed using his own best judgment "and consent on the part of the injured person would be implied." Similarly, if in the course of the operation the doctor discovered a condition which was not anticipated when the patient's consent to the operation was obtained, "and which, if not removed, would endanger the life or health of the patient," the doctor would be justified in extending the scope of the operation to remove or overcome this condition. Although it might appear at first glance that the latter situation had arisen here, the court pointed out that the condition of the left ear was not discovered in the course of the authorized operation, but was disclosed as a result of an unconsented-to examination of the left ear under anaesthetic. Also, there apparently was no serious danger to the patient inherent in the delay necessary to obtain consent.

Parmelia Davis suffered from epilepsy. While she was a patient in Dr. Pratt's sanitarium, the doctor performed two operations upon her body, and in the course of the second of these removed her

30. Mohr v. Williams, 95 Minn. 261, 267, 104 N.W. 12, 14, 1 L.R.A. (n.s.) 439, 443 (1905)
31. Id. at 268, 104 N.W. at 14, 1 L.R.A. (n.s.) at 443.
32. Id. at 269, 104 N.W. at 15, 1 L.R.A. (n.s.) at 444.
33. Ibid.
ovaries and uterus. While Mrs. Davis apparently understood that the operations would involve her womb and agreed to this, she did not know the full extent of the proposed operations. In an action brought for the performance of the operation without her consent, the doctor relied on the alleged consent of Mr. Davis, but the court found that consent to the removal of the uterus was lacking. The statement of the law paralleled that in *Mohr v. Williams* in that the court emphasized the right of the patient not to be touched except by consent and recognized that there might be exceptional circumstances in which consent was impracticable. Rather than speaking in terms of implied consent under these circumstances, the court said:

... it is the duty of the surgeon, in dealing with these conditions [the two exceptional situations mentioned above], to act on his own discretion, making the highest use of his skill and ability to meet the exigencies which confront him.

... In such event the surgeon may lawfully, and it is his duty to, perform such operation as good surgery demands, without such consent.

Here, as in the *Mohr* case, there appears to have been no evidence of these exceptional conditions. Indeed, there is some question as to whether the operation was even beneficial to the patient, since it did not appear to improve either her mental or physical health, and it deprived her of any further hope of having children. An argument was made that there was consent, on the part of the husband, to the removal of the ovaries and that "correct surgical practice" required the removal of the uterus at the same time so that consent to such removal should be implied. The court did not accept this argument, however, in view of the evidence that there was no consent by the patient to the removal of her ovaries and that the husband had not consented to their removal in the second operation.

Mattie Inez Strain had stepped on a nail which penetrated the great toe of her right foot and resulted in serious inflammation of the toe. She went to Dr. Rolater, who advised her that it would be necessary to make an incision in the toe in order to drain the infected joint and remove any foreign matter therein. Miss Strain agreed to the operation but extracted a promise from the doctor that he would remove no bones from the foot. After the patient was

35. *Id.* at 309, 79 N.E. at 565, 7 L.R.A. (n.s.) at 612.
36. It should be noted that Parmelia Davis was about forty years old and had already had four children. If the condition of her ovaries was as indicated in the defendant's testimony it is very unlikely that she would have been able to bear more children even had the operation not been performed.
under anaesthetic, the doctor discovered that the joint was covered by the sesamoid bone and that it would be impossible to drain the joint without removing the bone. The bone was in an unusual position, which could not have been ascertained by external examination prior to the operation itself. Although Dr. Rolater testified that serious consequences would have followed the operation without the removal of the bone, and although there was no evidence that the bone served any function in the foot, the patient was permitted to recover without proof of any lack of skill on the part of the doctor. The appellate court affirmed the judgment relying on the Mohr and Pratt decisions.37 The result in this case may appear to be more justifiable than in the prior two cases as there was evidence of a specific prohibition of the act done, i.e., removal of the bone. It may be argued, however, that in making this condition, the patient had in mind the cutting or removal of bones which served some useful function and the removal of which would at least cause inconvenience to her. The doctor argued that since there was no evidence that the sesamoid bone served any function and no evidence of any actual injury resulting from the operation, the plaintiff should not recover more than nominal damages. The appellate court rejected this argument and said that damages of $1,000.00 were not excessive on the ground that

Being composed of men of ordinary intelligence, [the jury] may have consulted their common experience, and reached the conclusion that every bone in the human body serves some useful purpose, and that the sesamoid bone in the plaintiff's foot served a purpose, and its removal might have resulted in injury, the testimony of the experts to the contrary notwithstanding. There was testimony that the foot was more or less deformed since the operation, that the joint was stiff, and that the patient could not wear a shoe for a long time thereafter, and that she had suffered almost constant pain in the injured foot since the operation. From the evidence, the jury might have found that the removal of this sesamoid bone was in a measure responsible for these unfavorable conditions (since the operation).38

In the last of these four cases,39 Mary Schloendorff had gone to the defendant hospital for the purpose of being examined under ether anaesthesia to ascertain the nature of an unidentified lump in her stomach. She claimed that at the time of consenting to this

38 Id. at 580, 137 Pac. at 99, 50 L.R.A. (n.s.) at 884.
39 Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914)
examination she had notified the doctor, "that there must be no operation." In the hospital, she was prepared as for an operation, and while she was under ether a fibroid tumor was removed from her abdomen. In an action brought against the hospital, the plaintiff's witnesses testified that as a result of this operation "gangrene developed in her left arm, some of her fingers had to be amputated, and her sufferings were intense." The issue facing the court was the extent to which a charitable hospital was to be held responsible for the acts of doctors and nurses. A verdict was directed for the defendant hospital. Judge Cardozo, writing for the Court of Appeals of New York, stated that a charitable hospital might be held not to be liable to a patient for the negligence of doctors and nurses on either of two theories: first, on the basis of an implied waiver by the patient entering a charitable institution (even though he or she paid for the care received), or second, on the basis that there was no master-servant relationship between the hospital and the doctors and nurses. The first of these reasons was deemed inapplicable to this situation because, as Cardozo said

In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault for which he is liable in damages. Pratt v. Davis; Mohr v. Williams. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained. The fact that the wrong complained of here is trespass rather than negligence, distinguishes this case from most of the cases which have preceded it. In such circumstances the hospital's exemption from liability can hardly rest upon implied waiver. Relatively to this transaction, the plaintiff was a stranger. She had never consented to become a patient for any purpose other than an examination under ether. She had never waived the right to recover damages for any wrong resulting from this operation, for she had forbidden the operation.40

The court did find, however, that the hospital might be excused from liability on the basis that no master-servant relationship existed between it and the doctors and nurses and because it was not cognizant of the fact that the operation being performed with its facilities was in disregard of the express orders of the patient. It should be noted that the distinction between trespass and negligence was merely a reason given for disregarding one basis for denying liability although liability was ultimately denied. Further-

40. Id. at 129-30, 105 N.E. at 93-94.
more, the court might have found lack of an implied waiver on the basis of express prohibition, whether the operation constituted negligence or assault. Therefore the statement quoted might be doubtful precedent for other decisions. Yet subsequent courts have quoted this statement readily. And on the facts of the case, the conclusion as to the nature of liability on the part of the doctors seems warranted. Serious damages resulted from the operation. It was performed in violation of an express prohibition, if the plaintiff's statements are to be credited. There was no "emergency" and all that the patient had consented to and sought to have done might have been accomplished successfully without performing the operation itself, from all that we have in the reports of the case. Of the four decisions, this seems the strongest for imposing liability without regard to the amount of care or skill exercised by the doctor and without regard to whether the operation could be classified as "good surgical practice."

If we accept the language of these four opinions as applied to the facts in each, the law of civil liability of doctors for unauthorized operations appears as follows. Every individual has a right to the inviolability of his person which forbids a surgeon or physician to invade the bodily integrity of his person. Whenever a surgeon or physician, without the patient's permission, performs an operation or renders medical treatment, he prima facie commits a battery. Exceptions will be recognized in unusual circumstances where it is impracticable to obtain the consent of the patient and where there is a serious threat to the life or health of the patient which must be dealt with immediately, either by rendering wholly unauthorized medical treatment or by extending the scope of an authorized operation to remove or overcome an unforeseen condition. The fact that the medical treatment to which there is no consent is not seriously harmful, or is in fact beneficial to the patient, does not excuse the doctor. Further, the fact that the treatment is conducted in accordance with the dictates of good surgery or medicine and is done in a skillful and careful manner does not constitute an excuse. As to all of these points the four cases are uniform.

On the other hand, the facts of the cases might lead one to draw distinctions as to the nature of the liability of the doctor. A case involving an express prohibition on the operation, as in the Schloendorff case, might be distinguished from one in which there was consent to an operation but the nature of the actual operation was not consented to, as in the Pratt case. A distinction might be drawn between an express prohibition to any operation and a limitation
imposed on the extent of the operation, as in the Rolater case. Finally, a distinction might be drawn between cases in which there is a showing of affirmative harm to the patient resulting from unauthorized treatment and a case such as Mohr, in which the operation in fact was beneficial and the only deviation from the consent was with regard to the right or left side of the body. A determination as to whether such factual distinctions should make a difference in the nature of the doctor's liability or should result in classifying one fact situation as an assault and battery and another as negligent malpractice will be delayed until after an analysis of other cases involving unauthorized, or unconsented-to treatment.

THE CASE LAW AND THE DOCTOR'S CONDUCT

In classifying the cases of unauthorized operations or similar medical treatment, a division may be made between those in which there has been some express prohibition or limitation on the part of the patient, those in which the doctor acts outside the scope of affirmative consent, and those in which the doctor has made a mistake. Before turning to this tri-partite division of cases, however, we should note some cases which appear to be related to our central problem but deserve separate treatment. These too fall into three categories:

The first of these categories include cases in which the doctor's conduct appears to go somewhat beyond the limits of "treatment." Illustrative of this category is a case such as Bryan v. Grace in which the plaintiff alleged that the defendant dentist, having made an appointment to treat the plaintiff's teeth at a time when no one else would be in the office, diverted from his usual course of treatment by preparing a pallet on the floor and engaging in gestures which led the plaintiff to fear that he intended intercourse with her. While the Georgia court held that there were no facts alleged to support a claim of assault and battery or any other legal wrong (apparently on the theory that something more than a mere invitation was necessary), the case is representative of the situation in which the doctor has taken advantage of his confidential relationship with the patient in order to gratify his own personal lust. A related case is that of Keen v. Coleman. There the doctor apparently became angered by the patient's refusal to continue a course of medication which he had prescribed. Under pretense of examining an incision resulting from his recent operation upon

42. 67 Ga. App. 331, 20 S.E.2d 175 (1942).
the patient, the doctor induced her to get onto an operating table and consent to a proposed treatment of the incision through her vagina and uterus. When she became aware that he was preparing to operate the patient protested, telling him she was pregnant "and for God's sake not to do anything to her that would cause her to lose her child." The doctor then inserted a surgical instrument into her womb and gave it "a sudden and violent whirling motion" which resulted in intense pain on the part of the patient and dismembered her unborn child. The doctor then abandoned the patient without rendering further medical attention and the patient made her way home unassisted. The court with remarkable restraint said that since the petition did not show that the doctor was acting in an emergency arising in connection with his claimed treatment of an infected incision, a cause of action for unauthorized operation was set forth by the allegation of the foregoing facts. In *Wellman v. Drake* the plaintiff alleged that the defendant dentist had exposed a nerve in her tooth and then refused to fill or treat it, but instead with great force and violence jerked the towel from around her neck, seized her and pulled her from the chair, shook her violently and ordered her from the office. Defendant moved to compel the plaintiff to elect to stand on a claim of malpractice or of assault and battery, and when she elected assault he moved to dismiss on the ground that she had not alleged an assault. The motion was overruled, but the appellate court reversed on the ground that the complaint was framed in terms of malpractice rather than assault and battery, and that there was no allegation of damage or injury independent of the failure to treat the tooth. This decision may have been influenced by the indications in the record that the dentist was merely trying to calm an hysterical patient, but the doctor's conduct again appears to have gone somewhat beyond the normal meaning of "unauthorized operation or treatment."

The second category of cases lying on the periphery of the central problem includes those cases in which treatment is given by a person who is not licensed to practice medicine. Where the defendant's act is malicious or in total disregard of the patient's welfare and he has consciously misrepresented his status to the patient, the courts have uniformly classified the situation as one of battery on the ground that the consent was obtained by fraud as to the very nature of the act done. On the other hand, where the treatment is

43. 130 W Va. 229, 43 S.E.2d 57 (1947).
44. See, e.g., *People ex rel. Burke v. Steinberg*, 190 Misc. 413, 73 N.Y.S.2d 475 (N.Y. City Mag. Ct. 1947) (defendant, in effort to impress her boy friend, pretended to vaccinate people and injected water), Commonwealth
itself proper and there is no evidence of malice on the part of the defendant, the courts generally do not speak in terms of battery, although a few have treated lack of a license as evidence of negligence.

A third category involves problems of illegal operations such as non-therapeutic abortions and sterilizations. Here imposition of liability upon the doctor in spite of the consent of the patient appears to be based more on the public policy against the operation itself than any considerations as to the intent of the doctor or the protection of the patient's rights.

Operation after Express Prohibition

Two of the leading cases which are classified under this heading have already been discussed. A distinction was noted between a prohibition against any sort of operation, such as in Schloendorff v. Society of New York Hospital, and consent to an operation which is then conditioned by a prohibition on a specific aspect of the operation, as in Rolater v. Stran. Does this distinction appear in other cases?

Mrs. Brooks went to Dr. Francis, a dentist, for the extraction of nine of her teeth. Dr. Francis recommended the further extraction of an impacted unerupted bicuspid, but Mrs. Brooks objected on the
ground that her own dentist had said that this involved a more serious operation than mere extraction. Although there was some conflict in the testimony as to whether the patient in fact consented, the dentist proceeded to remove the bicuspid by cutting away the jaw bone around the tooth to the point where there was so little bone left that the jaw was easily broken. Mrs. Brooks sued, originally alleging only "malpractice," but amending to include a claim for removal of the tooth without her consent. The dentist claimed that the amendment to the complaint was barred by the intervention of more than one year between the operation and the date of amendment, since the statute of limitations on an assault and battery was one year. A verdict for the plaintiff, Mrs. Brooks, was affirmed on the ground that the amendment "was not a separate cause of action, but a mere incident of the malpractice case, and the case still remained as it was in the beginning, an action to recover damages for malpractice." The operation was performed in connection with similar operations which were consented to, but the case appears to come closer to the Schloendorff case than to the Rolater case inasmuch as the extraction of each tooth may be treated as a separate operation requiring separate consent. Although this might lead to the conclusion that the argument for "assault and battery" is strengthened, the categorization of the claim as one for general malpractice may be somewhat justified on the ground that the act which was most harmful, i.e., breaking the patient's jaw, appears more like lack of care than an "intentional" infliction of injury.

In two Colorado cases there have been protests against treatment, both involving patients who were injured and rejected the medical attention of particular doctors. In Meek v. City of Loveland the plaintiff was forcibly taken to a county hospital by certain peace officers and while there his leg was amputated as a result of a gunshot wound. In an action against the city, the officers and the doctor who performed the operation, the court talks in terms of false imprisonment and negligence, but appears to hold the doctor only for negligence. In Cady v. Fraser the plaintiff suffered a fractured ankle and asked for treatment by an orthopedic surgeon.

50. Francis v. Brooks, 24 Ohio App. 136, 144, 156 N.E. 609, 612 (1926). The further statements in the case, to the effect that the doctor-patient relation continued for some time after the operation, seem to be unnecessary in deciding the statute of limitations problem where there was no concealment of the original wrongful act and where there was no particular claim of a "continuing" trespass.

51. 85 Colo. 346, 276 Pac. 30 (1929)
52. 122 Colo. 252, 222 P.2d 422 (1950).
The doctor employed by plaintiff's employer's compensation carrier said that the specialist was not needed and that the insurance company would not stand the expense. Plaintiff then ordered the doctor off the case, but the defendant continued to treat him. Although there was some evidence of acquiescence in this later treatment, the court's major argument for dismissing a charge of assault and battery seems to have been that there was also an allegation of negligent treatment and the two claims where wholly inconsistent, the assault and battery depending on lack of contract or authority and the negligence on the presence of authority. This would lead to the conclusion that in a case in which there was a clear proof of lack of authority the Colorado court would now threat the situation as one for assault and battery. In both of these cases the patients needed medical care but the particular care was foisted upon them against their wills, or apparently was. In each there was pain and suffering, although it may be argued with some merit that the doctor in fact reduced the harm to the plaintiff in each case by preventing more serious physical consequences. This might explain the failure of both decisions to clearly designate the fact situation as a battery. Some support for this comes from a similar case, *Ollet v. Pittsburgh, C.C. & St. L. Ry.*, where the plaintiff had been injured seriously and was taken in spite of his protests to a hospital and placed under the care of a doctor other than his own. There the court said, "The circumstances certainly seemed to call for great haste, and one who endeavors to assist his neighbor who is in great danger and distress is certainly not liable for a mistake in judgment." Although this latter case may fall within the "emergency" exceptions to the general doctrine of unauthorized operations, the general tone of the opinion is that one who in fact assists the plaintiff is not going to be dealt with severely.

Short of original prohibition of treatment is the situation in which the patient withdraws consent. For example, in *Bakewell v. Kahle* the plaintiff alleged that the defendant, a chiropractor, had made an erroneous diagnosis of a tumor or lesion of the brain as a misplaced vertebra and that, after the plaintiff had protested the method of treatment and had asked him to stop, the defendant had given her a more severe and harder thump. Plaintiff recovered a

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53. The only other Colorado case on the subject, at least after the Cody decision, is Maercklein v. Smith, 129 Colo. 72, 266 P.2d 1095 (1954), in which the court found that there was no question that a contract had been entered into and therefore the defendant's act was classified as "negligent." See a discussion of this case at p. 412 infra.

54. 201 Pa. 361, 50 Atl. 1010 (1902).

verdict on a claim for malpractice. The appellate court affirmed the judgment on the ground that although an unauthorized operation or treatment constituted an "assault" it also was "malpractice" even though there was no negligence charged. The situation appears similar to that in Rolater v. Strat, i.e., consent to general treatment followed by objection to a particular form of treatment which the practitioner believes to be necessary. The same degree of necessity present in the Rolater case may not be present here, however, and the consequences (inability to walk, impaired vision and partial paralysis) seem considerably more severe than those in the Rolater case. In Corn v. French\textsuperscript{56} the plaintiff had consented to an examination of her breast to determine whether there was cancer, at the same time stating to the doctor that he was not to remove her breast. On entering the hospital she signed a written consent "to perform an operation for mastectomy [removal of the breast] and to do whatever may be deemed necessary in his judgment" without actually understanding the meaning of "mastectomy." Following this she repeated her instructions that her breast was not to be removed, according to her testimony. The breast was removed, although later it appeared that there had been no cancer and although the doctor had not undertaken a biopsy (a microscopic examination of the tissue taken from a living body). The court reversed an involuntary dismissal of the complaint, saying that the question of whether the operation was consented to should have gone to the jury. Although the court did not characterize this particular claim as an assault and battery, it did deal separately with the question of negligence in relation to the failure to properly diagnose the condition.

The plaintiff in Donald v. Swann\textsuperscript{57} claimed a trespass to her person based on the defendant doctor's extraction of fluid from her spinal column in the course of a physical examination, a procedure to which she testified she had objected. The trial court refused to charge, as requested by the defendant, that if the patient had presented herself to the doctor for diagnosis, treatment and care, the doctor was authorized to use the ordinary and usual methods of diagnosis and treatment. On appeal this ruling was affirmed. The court distinguished between actions based on negligence and actions for assault and battery based on unauthorized operations, and cited not only Rolater and Schloendorff but also Francis v. Brooks\textsuperscript{58} and

\textsuperscript{56} 289 P.2d 173 (Nev. 1955)
\textsuperscript{57} 24 Ala. App. 463, 137 So. 178 (1931)
\textsuperscript{58} 24 Ohio App. 136, 156 N.E. 609 (1926), discussed supra pp. 394-95.
Hershey v. Peake, both of which appear to treat the unauthorized operation as something other than a standard assault and battery for purposes of avoiding the bar of a short statute of limitations. The report does not indicate the nature of the damage suffered by the patient, although some pain and suffering probably accompanied the spinal tap. Also there appears to have been no contradiction that the spinal tap was a necessary part of a complete diagnosis of the plaintiff's condition. This seems to make the case more like Rolater than Schloendorff or Francis.

Somewhat similar are the cases in which an anaesthetic has been given contrary to the patient's orders. In Woodson v. Huey where the patient had told her doctor that she did not wish to have a spinal anaesthetic but one was in fact administered with severe ill effects, recovery was allowed for battery against the anaesthetist who administered the anaesthetic. In Keister v. O'Neil the trial court directed a verdict for the doctor who had administered a spinal anaesthetic after an express prohibition. The appellate court conceded that there was undoubtedly a technical battery if the administration of the anaesthetic was contrary to the patient's orders, but refused to grant a new trial since there was no showing of actual damages resulting from such "battery." In Zink v. Basham the use of a spinal anaesthetic in the course of an examination of the plaintiff resulted in paralysis of her body below the waist. Although it appears that the patient had protested, the court talks almost exclusively in terms of negligence, which might be explained by the fact that the complaint was framed in terms of negligence, whereas in the Donald, Woodson and Keister cases there was an express claim for battery. In Bishop v. Shurly the plaintiff, mother of the minor patient, had expressed a desire that local anaesthetic not be used and claimed that the doctor had agreed to use a general anaesthetic. The patient apparently had requested a local anaesthetic immediately before the operation and the court treated this as sufficient in view of his maturity. While the court indicates that the administration of a local anaesthetic after agreeing to use a general would

60. ... Okla. ..., 261 P.2d 199 (1954).
61. The doctor who was to perform the operation was absolved from liability because he had noted the limitation on anaesthetic on the patient's chart, had spoken to the anaesthetist and was not present when the spinal anaesthetic was administered.
63. The actual prohibition in this case came not from the patient, but from her husband and mother-in-law, due both to the patient's minority and to her temporary incapacity to consent.
64. 164 Kan. 456, 190 P.2d 203 (1948).
give rise to a cause of action, it also speaks in terms of a “breach of an obligation” and “proximate cause,” which terminology is normally associated with negligence claims rather than claims for trespass to the person.

Other situations involve prohibitions as to the extent of the operation. One of the early cases presenting a problem of unauthorized operation was *Beatty v. Cullingworth*, not officially reported but mentioned in several other sources. The surgeon was performing an ovariotomy. Prior to the operation the female patient told him that if he found both ovaries diseased he must remove neither as she was going to be married shortly. The surgeon testified that he then said, “You must leave that to me” and “you may be sure that I will not remove anything I can help,” but the patient denied having heard these statements. In the course of the operation both ovaries were found to be diseased and the surgeon concluded that the patient’s life and health would be imperilled by failure to remove both. The trial judge charged the jury

> If a medical man, with a desire to do his best for the patient, undertakes an operation, I should think it is a humane thing for him to do everything in his power to remove the mischief, provided he has no definite instructions not to operate. There was here no question as to the propriety of the operation, and the defendant always told the plaintiff she must give him a free hand. If you think tacit consent was given, you must find for the defendant.

The jury found for the defendant doctor. This decision may be made on the basis of a finding of consent, at least implied from the patient’s continuing to submit to the operation after the statements of the doctor. It is perhaps noteworthy that in referring to this case, Halsbury’s Laws of England contains the comment

> In the majority of cases there is doubtless an implied consent to do what the surgeon, without negligence, considers necessary and desirable. This consent would be negatived by express instructions not to do certain things, but if a surgeon found that it was necessary to do these things and did them against instructions, it is difficult to see, apart from some special circumstances, what damage the patient would have suffered.67

*Perry v. Hodgson*68 involved an operation on the plaintiff’s leg which had been crippled by a childhood disease. In giving his

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67. 22 Halsbury, Laws of England 319 n. (f) (Hailsham ed. 1936)
sent, the patient's father (the patient being a minor) specifically said that he did not want the surgeon to go near the hip joint nor to affect a "track" through which infection in that joint was drained. The surgeon did cut into the hip joint, which, it was alleged, caused further pain and permanent crippling of the plaintiff. Plaintiff brought an action alleging violation of the agreement, breach of a duty owed to him and trespass to his person. Defendant denied that there was an agreement and pleaded that he had used proper skill and care in the operation. Further, the defendant introduced expert testimony to the effect that the operation was a proper one. The defendant obtained a verdict. The Supreme Court of Georgia reversed, saying that the case was a suit for damages arising out of a trespass and that the issues in the case should have been confined to trespass and that.

Where a surgeon enters into an agreement with a person merely to perform a certain operation, and the surgeon in violation of that contract goes further without an emergency, and performs another operation which is unauthorized by the agreement, or by an emergency necessitating the additional operation, and injury results, he cannot relieve himself from liability by pleading and showing skill and care in the additional operation.69

Again, unlike the Rolater case, there was no pressing necessity shown and the damages resulting from the operation were substantial.

In Dicenzo v. Berg70 the patient suffered from a bone chip imbedded in his shoulder or lower neck. The doctor told him that "We are going to operate on you on top of shoulder [sic]." The patient said, "Don't go too much up in the neck." When the operation was completed the patient sued claiming that it had involved his neck and was therefore performed without authority. The trial court directed a verdict for the defendant on the issue of negligence, which was also pleaded. The jury disagreed on the issue of whether there had been consent. On appeal from the denial of the doctor's motion for judgment, the Pennsylvania court said that even laying aside a written general consent executed by the patient upon entering the hospital and the evidence of the defendant's witnesses to the effect that the patient had orally consented as well, there was not sufficient evidence to sustain a finding that the patient had not consented "to such operation as was considered necessary by the surgeon to alleviate the conditions with which plaintiff was suffering.

69. Id. at 687, 148 S.E. at 662-63.
Plaintiff’s evidence shows he knew the neck would be involved in the operation.” While the case turned more on the nature of the consent of the plaintiff than on the nature of the defendant’s acts, it illustrates the distinction suggested previously between the situation in which there is no consent at all and that in which there is consent to the general treatment and accomplishment of a certain objective but the patient attempts to impose conditions on the manner in which the operation is to be performed. More than this, it suggests that if the patient is cognizant of the likelihood of a particular part of his body being involved in the operation and does not make his prohibition on such an extension of the operation clear, he may be taken to have consented.

In a recent case the doctors, making an examination of the patient’s throat in connection with the possibility of a cancer there, cut a piece off of an edematous polyp, although the patient alleged that she had said specifically that she wanted only a laryngoscopic examination and that there definitely was to be no cutting. The defendant doctors testified that prior to the operation they explained to the patient that the diagnosis could not be complete without obtaining a specimen for a biopsy, and claimed that the patient had consented. Judgment for the doctors was reversed on the ground that it was improper for the trial court to exclude the testimony of the patient’s family physician to the effect that he had called defendants’ office and had told the receptionist specifically that there was to be only a visual examination and “no biopsy or cutting was to be done.” The conclusion to be drawn from this ruling is that if such instructions were in fact given, there would be a cause of action even though the examination undertaken would have been incomplete without the clipping. There is no statement in the facts recited by the court that the plaintiff in fact suffered any permanent or severe harm as a result of the actions of the doctors.

In the cases involving an express protest or prohibition there appear to be two factual situations which may be distinguished— one where the treatment is wholly unauthorized as in Schloendorff, Francis, Meek, Ollet, Corn and possibly Cady, the other where there has been consent to a general type of treatment or submission to the care of a doctor for a specified objective but with some limitations imposed on the method of treatment which the doctor has disregarded in the exercise of his own judgment, as in Rolater, Beatty, Perry and possibly Dzenzo. The cases of limitations on the use

71. Id. at 309-10, 16 A.2d at 17
72. Marshall v. Harter, 262 S.W. 2d 180 (Ky. 1953)
of certain diagnostic methods, *Donald v. Swann* and *Marshall v. Harter*, or of prohibition of the use of local anaesthetics, *Woodson, Keister, Zink* and *Bishop*, might be classified in the former category on the ground that these methods and particularly the use of a specific type of anaesthetic are separable from the consented-to operation or treatment.

Where the patient has made it clear that he wants no treatment or operation on a given portion of his body the argument is strong that the doctor's performance of an operation is an intentional invasion of the plaintiff's bodily integrity. When there is added the existence of actual harm resulting from such invasion, as in *Schloendorf, Corn, Francis, Woodson*, and *Zink*, the classification of the defendant's conduct as a "battery" would be justified by tradition. Yet it should be noted that in *Francis v. Brooks* the court refused to apply the "assault and battery" statute of limitations and grouped the conduct with the general category of negligent malpractice; and in *Zink v. Basham* the court treated the conduct as "negligence." Where the intentional invasion is not accompanied by any clear showing of harm resulting directly from the invasion itself, as in *Meek, Cady* or *Ollet* (assuming that in these cases the doctors in fact conferred benefit on the patients) and in *Donald, Keister* and *Marshall v. Harter*, the courts which would classify the conduct as "battery" would be vindicating only the plaintiff's right to make the decision as to medical care himself. It is significant, therefore, that only in the *Donald* and *Keister* cases did the courts use this classification.

Where the patient has given general consent to the treatment but has imposed specific limitations, the same subdivision may be made between infliction of actual harm and an invasion which does not clearly cause harm. In the cases in which there was apparently some harm, *Bakewell* and *Perry*, the court spoke in terms of "battery." In *Beatty, Rolater* and *Dicenzo* whether there was any actual loss to the plaintiff may be questioned. No recovery was had in two of these cases. In *Rolater* the court again seems to have been vindicating the right of the patient to make her own decisions rather than actually compensating for harm which was directly traceable to wrongful conduct on the part of the doctor. The merits of such classification are weaker here than in the situations in which there has been total lack of consent. In each of these cases the patient

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73. Restatement, Torts § 13 (1934). It is also true that physical harm is not a *sine qua non* for a finding of "battery." Prosser, Torts 31-32 (2d ed. 1955); Restatement, Torts § 18 (1934).
entrusted his or her body to the doctor for the purpose of receiving medical assistance for some physical ailment. It may well be argued that the patient's limitation on the nature of the treatment arose from misapprehensions as to the dangers involved in a particular type of operation, such as the removal of the sesamoid bone, or as to the risks inherent in not doing as the doctor in fact did, i.e., the possibility and danger of poison or disease spreading from the diseased tissue throughout the body. If a doctor is to perform his professional services most effectively, he must have some discretion as to the manner of treatment. Dr. Hubert Winston Smith, one of the leading authorities on legal medicine in this country, has said:

It follows from a patient's right to withhold consent and prohibit life saving surgery, that he can impose terms and conditions on his consent. A surgeon should not bind himself to conditions which are incompatible with good surgery, for by doing so he contracts away the professional judgment which may be necessary to proper performance of his main task.\(^74\)

The same sort of argument could also be made as to the necessity for removal of spinal fluid or body substances in order to make a complete diagnosis of the patient's disease or illness.

The courts have uniformly recognized that there is one situation in which broad discretion is proper, i.e., where there is an emergency involving life or serious injury to the patient and the consent of the patient is impracticable to obtain.\(^75\) Perhaps this same sort of discretion could be extended to cover the situation where a reasonable and prudent physician or surgeon would have considered that the condition should be corrected and would have approved the treatment or operation. The major argument against such an extension of the existing discretion of the doctor appears to lie in the interest of the patient in making his own decision. Yet in most of the cases involved here the patient at the time of laying down the prohibition did not know all of the facts, and in most of them there was no way that he or she could know all of the facts at that time. May it not be more in the interests of patients in such a situation to give the doctor rather broad discretion? Dr. Smith has suggested the difficulty in requiring that the patient make the ultimate decision without the guidance of expert knowledge which the doctor has, and frequently without having all of the information which the doctor later obtains. He has concluded:

\(^{74}\) Smith, Antecedent Grounds of Liability in the Practice of Surgery, 14 Rocky Mt. L. Rev. 233, 238-39 (1942)

\(^{75}\) See p. 388 supra.
unless the prohibition is sweeping and precise, courts should always hold that loose restrictions are to be confined by reading them in the light of facts known pre-operatively. It is fair to assume that if the unconscious patient knew of the discovery of a materially different condition, so grave as to constitute a threat to life or health unless relieved by immediate surgery, he would renounce his prohibition and instruct the surgeon to proceed. In laying down the vague prohibition, a patient expresses his vague fears of surgery and his secret dread of unnecessary or experimental measures. The very fact that he was willing to trust the surgeon to correct what both thought was the specific cause of his complaint, indicates that the patient is mainly concerned about getting out as lightly as possible.  

This would limit the surgeon's discretion, as the courts do, to those emergencies which arise after consent is impracticable to obtain and where the operation is necessary to save life or health. Some argument might be made that the latter term is broad enough to give the doctor sufficient discretion. However, the result in such cases as Rolater or Marshall v. Harter indicates that the courts are apt to read "threat to health" rather narrowly.

**Operation Beyond Terms of Consent**

Where there has been no express prohibition nor protest to an operation or treatment, the patient may contend that he had only consented to a specified operation or specified treatment and that the doctor has undertaken to render more extensive or different treatment. In such a situation should the courts classify the doctor's acts as a battery subject to the traditional incidents mentioned above?  

Or should the patient be forced or permitted to rely upon the more general charge that the doctor has failed to measure up to the standard of conduct established by the practice of a reasonable doctor of good standing in the same or similar locality and of the same school of medicine?

The fact situation which comes closest to that of an express prohibition appears in *Physicians' and Dentists' Business Bureau v. Dray*. The patient had consented to an examination under anaesthetic for the purpose of making certain laboratory tests. While she was under the anaesthetic the doctor removed her uterus. The facts resemble those of the *Schloendorff* case except that there apparently was not express prohibition on the part of the patient to the per-

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77. See pp. 383-84 supra.
78. 8 Wash. 2d 38, 111 P.2d 568 (1941).
formance of an operation. Since the ostensible object of the anaesthesia was only to enable the doctors to make an examination and laboratory tests, such prohibition of a more extensive operation may not have appeared to be necessary. Although the court acknowledged that an unauthorized operation would be an assault and battery, it went on to classify the claim of the patient in this case as one for "injury to the person" in common with negligence, to avoid the shorter period of limitations applicable to assault actions. In doing this, the court found support from decisions in some of the states in which the courts had classified an unauthorized operation as an assault.

Mohr v. Williams is another leading example of operations performed without express prohibition which are nonetheless treated as unauthorized. There the consent had been to an operation on the right ear but the operation was actually performed upon the left ear. As indicated above, the court treated this as a battery and permitted recovery in spite of the fact that the operation had been generally beneficial and skillfully performed.

In a similar case, Bennan v. Parsonnet, the patient had consented to an operation on the left groin for a rupture. After the patient was under anaesthetic, the surgeon's assistants pointed out that a much more serious condition existed in the right groin and upon closer examination the doctor found a hernia which was in danger of strangulation. If this had occurred, death appeared to be the probable result. The doctor operated on the right groin. In an action brought for assault and battery, the trial court charged that an operation without consent would be a legal wrong but that if, after the patient was under anaesthetic, a condition was discovered which threatened life and health, the consent of the patient to correction of such condition should be inferred. The jury found for the plaintiff. Judgment for the plaintiff was reversed on appeal, the appellate court stating that unimpeached medical evidence established that the hernia was a menace to life and health. The court cited the Mohr decision, but said that the common law view, that

79. There was an allegation in the complaint to the effect that the operation was performed "against her will" but no mention of a specific prohibition.
81. 95 Minn. 261, 104 N.W. 12, 1 L.R.A. (n.s.) 439 (1905), discussed pp. 387-388 supra.
82. 83 N.J.L. (54 Vroom) 20, 83 Atl. 948 (1912)
the patient was entitled to recover whenever there was no consent, must be modified as a result of the advent of anaesthetics which changed the circumstances of the operation. The court pointed out that it was frequently impossible to make a complete diagnosis before the patient was under anaesthetic and thereafter consent to all necessary operations would be impossible to obtain from the patient himself. To remedy this situation the court proceeded to designate the doctor as the representative of the patient for the purpose of determining whether any operation was necessary and what operation was necessary. This would not mean that the doctor could never be held responsible, however, for the implied authority to make such determinations would not afford the doctor "license to operate upon a patient against his will or by subterfuge, or to perform upon him any operation of a sort different from that to which he had consented, or that involved risks and results of a kind not contemplated." On the facts before it, the court may have been justified in concluding that, since the patient had submitted to a hernia operation and had contemplated the risks involved in such an operation, there was no serious departure from the express consent in performing the same operation on the other side of the body. The real significance of the opinion, however, is in its recognition that strict compliance with a requirement of actual consent might "paralyze the judgment of the surgeon and require him to withhold his skill and wisdom at the very juncture when they are most needed, and when, could the patient have been consulted, he would manifestly have insisted upon their being exercised in his behalf." While this does not completely reject the "battery" classification, it suggests that the court may look to what is reasonable medical practice under the circumstances.

Miss Hively consented to an operation on the septum of her nose by Dr. Higgs, an eye, ear, nose and throat specialist. In the course of the operation, Dr. Higgs removed Miss Hively's tonsils, thereby, according to her amended complaint, "causing plaintiff to suffer great physical pain and will for all time to come cause plaintiff to suffer great physical pain." The court did not follow the reasoning of the Bennan case but found liability, saying that there was no new condition discovered in the course of the operation which could not have been discovered prior to the operation and that there was no mere general instruction on the part of the patient that the doctor should do whatever was necessary in his judgment for

83. Id. at 25, 83 Atl. at 950.
84. Id. at 27, 83 Atl. at 951.
the benefit of the patient. In answer to the argument of the defendant, Dr. Higgs, that damages should be limited to a nominal one dollar on the ground that there was no showing of harm, inasmuch as the tonsils served no useful function, the court said that there was a presumption that every organ in the body served some function and that the presumption was not overcome by the fact that medical science had not as yet discovered the function of the tonsils. Also the plaintiff had testified that she had suffered great pain and that her throat still bothered her. In a more recent decision, Reddington v. Clayman, another court found that the removal of a child's uvula in the course of an operation to remove tonsils and adenoids would give rise to a cause of action for battery if the jury did not find that the parents' consent was broad enough to cover this organ. It did not appear that there was any special damage done to the child, and the doctors testified that the uvula did present some danger to the child's health in their opinion.

The case of Valdez v. Percy presents an unusual situation. The patient suffered from enlarged glands of the right axilla (armpit). The doctor told the patient that an operation was advisable to remove the gland and send it to a laboratory to determine the nature of the tumor. The patient consented to such a procedure. The first report back from the laboratory indicated that there was "carcinoma of the breast" but this was shortly amended to indicate only the presence of Hodgkins' disease which affected the axillary glands. The doctor removed the right breast. The conflicting reports from the laboratory were apparently the result of some confusion as to the source of the specimen sent to the laboratory. In an action brought by the patient, the court felt that the doctor did not have sufficient reason for the removal of the breast and reversed the granting of a nonsuit by the trial court. It is not clear that the appellate court was thinking purely in terms of battery rather than negligence, possibly because the patient had signed a general consent to "any and all operations which may be deemed advisable." However, it did rely upon Hively v. Higgs, which speaks of battery, and the decision has been cited in subsequent California opinions as though it were a case of assault and battery. The court indicated that the question of consent would be one for the jury, and on retrial the plaintiff

86. 134 N.E.2d 920 (Mass. 1956).
87. 35 Cal. App. 2d 485, 96 P.2d 142 (1939)
recovered only on the negligence claim but not on the claim for assault and battery.\footnote{89}

In the foregoing cases, the patient had consented to an operation on a designated portion of the body and the operation to which objection was made was performed on another distinct portion of the body. A much more common occurrence is the situation where there is a semi-exploratory operation in the abdominal region with consequences which the patient did not anticipate. This is particularly likely to occur in cases involving the female organs. \textit{Pratt v. Davis}\footnote{90} is probably the leading case in this area. In another early case, \textit{King v. Carney},\footnote{91} the patient had been informed by her family physician that the reason for her frequent miscarriages was laceration of the uterus. The patient went to the defendant doctor and told him, "I want to be fixed so I can bear children, and we will never be happy without that." The defendant confirmed the diagnosis of laceration of the uterus and told the patient, "I will fix you up, and you can go back home before long and it will be all right." While the patient was under anaesthetic, the defendant discovered that both ovaries and the fallopian tubes were infected and that the patient could never bear children. He removed the diseased organs. In an action brought for unauthorized operation and negligence, the trial court excluded evidence offered by the defendant to establish that the fallopian tubes and ovaries were so badly diseased that it was necessary to remove them to safeguard the patient's life and health. The appellate court reversed judgment for the plaintiff, holding this ruling to be error, and stated that the patient had submitted herself to the operation for the purpose of being cured if possible, and that when the doctor discovered an unanticipated condition which constituted a danger to life and health he was authorized to extend the operation to correct it. In other cases, however, the doctors have not been so fortunate. For example, the Ohio Supreme Court in \textit{Wells v. Van Nort}\footnote{92} said that a woman who had submitted to an operation for appendicitis could recover for the removal of her fallopian tubes when there had been no mention made of such a result and the doctor had indicated that the appen-

\footnotesize{89. See Valdez v. Percy, 35 Cal. 2d 338, 217 P.2d 422 (1950) for the appeal from this second trial on the issue of negligence. This case was originally tried in the year 1934, reached the District Court of Appeals in 1939 on the first trial, was retried in 1948 some fifteen years after the original operation, and finally reached the Supreme Court of California in 1950. 90. 224 Ill. 300, 79 N.E. 562, 7 L.R.A. (n.s.) 609 (1906), discussed pp. 388-89 supra. 91. 85 Okla. 62, 204 Pac. 270, 26 A.L.R. 1032 (1922). 92. 100 Ohio St. 101, 125 N.E. 910 (1919).}
dectomy would be a relatively simple operation. The doctor there testified that he could have treated the tubes, but that there was a good chance that the patient would be back in the hospital within two months. Similarly in *Tabor v. Scobee* the court allowed recovery for the removal of fallopian tubes without the consent of the patient when there appeared to be no immediate emergency. Reversing the situation somewhat, the Illinois Court of Appeals in *Church v. Adler* would permit the patient to recover for removal of her appendix when she believed that the operation was for the removal of her ovaries, and the court in *In re Johnson's Estate* permitted recovery for the removal of an appendix where the patient had consented to the removal of a tumor which was not in fact removed. In both of the last two cases the main thrust of the plaintiff's complaint was the negligence of the doctor in failing to remove the designated organ or growth, and the courts seemed to treat the cases more as instances of negligence than as assaults. In a number of cases, however, the courts have given the doctors wide discretion in operating where the diseased fallopian tubes constituted a threat to health and where in the doctors' best judgment an operation was necessary. In such cases considerable weight appears to have been placed on the fact that the patient has submitted to the doctor's care for the purpose of being cured of her ailment and that the precise nature of the operation is really incidental to this main objective, whereas in the *Wells, Tabor, Church* and *Johnson* cases, the doctor had been fairly specific in the original diagnosis.

Where the patient consents to an operation upon a given portion of his body and the actual operation performed is materially different in the sense that it involves greater risk to life and health or involves a longer period of recovery and results in more serious consequences than the patient anticipated, some question may be raised as to whether or not there is an authorized operation. Perhaps some of the prior cases should be classified as involving this situation. In *Pratt v. Davis*, *King v. Carney*, *Russell v. Jackson*, and

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93. 254 S.W.2d 474 (Ky. 1952)
95. 145 Neb. 333, 16 N.W.2d 504 (1944).
97. See note 90 supra.
98. See note 91 supra.
99. See note 96 supra.
Wheeler v. Barker,\textsuperscript{100} the patients appear to have had some idea that the organs which were in fact removed might be affected by the operations. The same situation appears to have occurred in Dicenzo v. Berg.\textsuperscript{101} In all but the Pratt case, the courts found no liability, and in Russell and Wheeler and Dicenzo the courts relied on the fact that the patients knew of the general scope of the operations, although in each it appears that he or she did not know of the actual consequences.

In an early Michigan case, Zoterek v. Repp,\textsuperscript{102} the patient claimed that the doctor had described the proposed operation as a minor one, designed only to relieve a "retroverted uterus," and that subsequently he had obtained her consent to a second operation which he indicated was merely to repair a hernia which had developed as a result of the original operation. In fact the doctor had removed both of the patient's ovaries. Although the patient alleged that she had specifically told the doctor that she did not wish her ovaries removed, the appellate court found that there was sufficient evidence to support the trial court's charge to the jury that the patient had submitted to the operation understanding the possible consequences. In Paulsen v. Gunderesen\textsuperscript{103} the patient suffered from ear trouble and placed himself in the hands of the defendant who told him that the proposed operation would be a "simple" mastoid operation unaccompanied by any danger. The operation proved to be a "radical" one in the course of which the facial nerve was severed and the patient's face was paralyzed on one side. The court stated that there might be recovery for "assault" if there was a material change in the nature of the operation, but it limited recovery to exclude the expense, pain and natural or necessary results of the simple operation to which the patient consented. In Bonner v. Moran,\textsuperscript{104} where a minor agreed to provide skin for a graft onto his burned cousin, the court allowed recovery on the ground that he did not appreciate the danger involved. The plaintiff in Wall v. Brin\textsuperscript{105} agreed to what was supposed to be a minor operation to remove a cyst but which turned out to be a much more serious operation resulting in partial paralysis of the patient's face. The court permitted recovery for what it called a "battery" and stated that there had been no showing of lack of skill or proper care in the original

\textsuperscript{100} See note 96 supra.
\textsuperscript{101} 340 Pa. 305, 16 A.2d 15 (1940), discussed at pp. 401-02 supra.
\textsuperscript{102} 187 Mich. 319, 153 N.W 692 (1915).
\textsuperscript{103} 218 Wis. 578, 260 N.W 448 (1935).
\textsuperscript{104} 126 F.2d 121 (D.C. Cir. 1941).
\textsuperscript{105} 138 F.2d 478 (5th Cir. 1943).
diagnosis or subsequent operation. *Beringer v. Lackner*\(^{106}\) involved a patient who consented to a curettment of her uterus and womb but was subjected to a vaginal hysterectomy when the curettment proved to be impossible to perform. The court there sustained a claim of assault and battery, citing *Pratt v. Davis*. In *Maercklein v. Smith*,\(^{107}\) the plaintiff had originally talked to the doctor about a circumcision and when he returned to the doctor's office some six months later, he said he wanted "the operation." A vasectomy was performed which sterilized the plaintiff. The trial court directed a verdict for the plaintiff. The Supreme Court of Colorado reversed on the ground that there was some question as to whether the original agreement had been so clear that a violation of its terms would be "negligence," and directed the trial court to submit this question to the jury. It also dismissed a claim by the defendant that the action was barred by a one-year statute of limitations on assault and battery. In *Adams v. Boyce*,\(^{108}\) the patient entered the hospital to have a piece of metal removed from his eye. He claimed that he believed the doctors were going to use only a large magnet to withdraw the metallic splinter, but in fact it was necessary to cut open the eye ball. Following the operation the patient's eye swelled shut and he eventually lost the sight of that eye. Patient brought an action alleging assault and battery as well as negligence, and was nonsuited. The nonsuit was affirmed on the basis that there was no evidence of negligence and that the patient had submitted to the doctor's care for the removal of the object and could not be taken to have consented only to the use of the magnet. In each of the cases there was substantial harm resulting to the patient, and in most cases in which the court or jury found that the operation went beyond the scope of consent the conduct of the defendant was treated as a battery.

In other cases involving extension of the operation beyond the scope of consent there has been substantially less serious harm. For example, in *Nolan v. Kechjian*,\(^{109}\) the patient consulted the doctor about pains in the region of the stomach and was told that an operation was needed to strengthen the ligaments of her spleen. She was told that such an operation was not serious, but in fact her spleen was removed. There was medical evidence that the spleen was not diseased but there appears to have been no serious after-

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106. 331 Ill. App. 591, 73 N.E.2d 620 (1947)
107. 129 Colo. 72, 266 P.2d 1095 (1954)
109. 75 R.I. 165, 64 A.2d 866 (1949)
effect of its removal. The patient was permitted to maintain an action for trespass to the body as well as for negligence. In McGuire v. Rix, the patient had fractured her ankle. The doctor tried manual manipulation and while the patient was under anaesthetic cut into her foot to set the bones. He had not told her that any cutting would be necessary, although it appears that this was a necessary procedure in this case. The patient complained that the cutting was unauthorized. A dismissal of her action was affirmed on the ground that there was no evidence of negligence and that when it became apparent that manual manipulation would not be sufficient, it was not necessary to revive the patient to obtain her consent since “consent may be implied from circumstances and an operation may be demanded by an emergency without consent.” Some reliance was placed on the fact that the patient had said to the doctor that he must not cut off her foot, which was some indication that she was not wholly without appreciation of the risk of some surgery. In two older cases, Slater v. Baker & Stapleton and Boydston v. Giltner, the doctors refractured broken limbs allegedly without the consent of the patients. In each of these cases the courts dealt with the problem as one involving a breach of the standard of care normally exercised by physicians rather than as strict assault and battery cases. While some pain and suffering undoubtedly resulted, there is no particular reason to assume that the resulting condition was any worse than would have been the condition of the patient’s limb if no such treatment had been undertaken.

A separate problem is raised by cases in which the doctor, in the course of an authorized operation or treatment, goes beyond the scope of consent in order to repair a condition found or to remedy an injury resulting from the operation itself. In Franklyn v. Peabody, the plaintiff consented to an operation designed to correct a stiff finger. The doctor discovered, on opening the hand, that the tendons had adhered and concluded that it would be necessary to sheathe each tendon in additional fascia, which he obtained from the fascia lata of the right thigh. The plaintiff complained that the operation on the thigh resulted in a muscle hernia and caused pain and disability. Recovery was permitted, the court citing the Pratt, Mohr and Rolater decisions and rejecting the defendant’s claim that he had performed according to the dictates of “good surgery.” On the latter point the court said, “An unauthorized

110. 118 Neb. 434, 225 N.W. 120 (1929).
112. 3 Ore. 118 (1869).
113. 249 Mich. 363, 228 N.W. 681 (1930).
operation may be well performed and in line with good surgery and still afford no excuse for such a trespass to the person." While it might have been argued that this was one of the unanticipated conditions as to which physicians and surgeons are given discretion to act, there was no serious threat of death or injury to the health of the patient, so the court thought.

In Markart v. Zemer, the plaintiff alleged in the first count of his complaint that he had submitted to a hernia operation in the course of which the defendant doctors negligently closed off the blood to his right testicle and negligently made an incision in said testicle, and in the second count alleged that the doctors did the foregoing and also performed a second operation without the patient’s consent in which they removed the testicle. Verdict for the plaintiff was reversed by the appellate court on the ground that there was no evidence of negligence in cutting off the blood or nerve connections in the first operation and that the issue of negligence should not have been submitted to the jury. The jury did recognize that there might be a valid claim for unauthorized operation if this issue were submitted separately to the jury. It may be argued that if there was no negligence in the initial operation and if the subsequent operation was necessary to “repair” a condition which threatened serious harm, there should be no liability on the part of the doctors so long as they acted reasonably in the performance of the second operation. This may have been in the back of the court’s mind, since there is a statement that “Plaintiff’s case is founded on the claim that the operation was negligently performed,” and in a later decision on the question of the costs of the appeal, the court refers to the case as one for injuries “directly produced by defendant’s negligence.” Furthermore, in a more recent decision in the same jurisdiction, Preston v. Hubbell, the court appears to have adopted this approach. In this later case the patient had gone to the defendant dentist for the removal of an impacted wisdom tooth. In the course of the removal, the patient’s jaw was broken and the dentist repaired it while the patient was under anaesthetic. The patient suffered some ill effects and sued for negligence in the removal of the tooth and for the repair of the jaw without her consent. The court reversed judgment on a verdict for the defendant, on the basis of erroneous instructions on the issue

114. Id. at 368, 228 N.W. at 683.
116. Id. at 368, 227 Pac. at 684.
of contributory negligence, but accepted the argument of the dentist that the patient must be taken to have consented to the performance of any emergency work which became necessary in order to completely repair a condition developing during the operation. Although the court relied on cases involving unauthorized operations as batteries, it did say that the claim of want of consent was merely incidental to the alleged unskillfulness in the performance of the operation to repair the jaw. This at least raises some question as to whether the California court would treat such a claim, framed exclusively in terms of unauthorized operation, as an action for assault and battery or an action for negligence.

In another action in which the patient claimed that there had been no consent to other than a hernia operation and that the defendant had removed a testicle without his consent, the court accepted the doctor’s defense that the removal was a necessary part of the operation, the necessity of which could not reasonably have been ascertained by diagnosis prior to the beginning of the operation. The court spoke of unanticipated conditions arising during the course of operation as justifying the doctor exceeding the consent of the patient, but rejected the argument that there was any “implied consent” or that the physician became a “representative” of the patient for the purpose of giving consent. Rather it relied on the existence of a duty on the part of the doctor to act in order to preserve the life and health of his patient. While this might lead to an argument that where good surgery demands a certain operation the doctor may be justified in exceeding the terms of consent, the court said that “good surgery” was too general, vague and ambiguous to be the basis of the defense. This court talked in terms of “assault and battery” and said that but for the defense of an emergency, the action would be barred by the statute of limitations for assault and battery.

In *Gregoris v. Manos*, the doctor was employed to treat the groin, appendix and rectum of the patient and in the course of such treatment injected a needle into a cyst to withdraw fluid. It appears that a vein was torn and the doctor operated to tie off this vein. The patient brought an action, alleging in the original and two amended petitions that the operation was performed without his consent, but omitting this allegation in the third amended complaint which was framed in terms of negligence. The appellate court affirmed judgment for the defendant doctors, saying that had the

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120. 40 N.E.2d 465 (Ohio App. 1941).
plaintiff retained the allegation of operation without consent he would have been entitled to a charge that if the jury found no consent to the operation the plaintiff should recover. Here, however, there was some indication that the entire course of treatment had been directly contrary to the description given to the patient by the doctor prior to the insertion of the needle. The argument seems fairly strong that if there was consent to the original treatment and if there was no negligence in that treatment itself, the doctor should be justified in performing an operation to prevent the internal bleeding which would have followed the tearing of the vein.

In several cases where doctors have performed operations to remove needles,\textsuperscript{121} pads,\textsuperscript{122} and other instruments\textsuperscript{123} which have been left nonnegligently in the body, the courts have found no liability for the second operation. These may be reconciled with such decisions as the \textit{Franklyn}, Markart and Gregoris decisions on the basis that in one set of cases there is immediate need for such unauthorized conduct while in the latter cases there is no such immediacy. No very definite guide to the presence of an “emergency” can be developed from the cases, however. It seems likely that the resolution of the question of liability in such cases will ultimately turn on expert evidence as to whether a reasonable doctor would consider that an “emergency” existed and proceed to operate.

In summary, in the cases involving operations or treatment which went beyond the scope of the patients’ consent, the courts predominantly classify the defendant’s conduct as an assault and battery. When the operation performed is completely unauthorized, as in \textit{Physicians’ & Dentists’ Business Bureau v. Dray}, or where it is performed on an entirely unauthorized portion of the body, as in Mohr \textit{v. Williams}, Hively \textit{v. Higgs}, Reddington \textit{v. Clayman}, Valdez \textit{v. Percy}, or \textit{Franklyn v. Peabody}, or varies greatly from the character of the operation as consented to, as in Pratt \textit{v. Davis}, Wells \textit{v. Van Nort}, Tabor \textit{v. Scobee}, Paulsen \textit{v. Gundersen}, Bonner \textit{v. Moran}, Wall \textit{v. Brum} or Maercklein \textit{v. Smith}, the doctor must have realized that he was going outside the scope of the permitted operation and so his conduct is properly classified as “intentional” in the sense that he knows he has invaded an interest of the plaintiff-patient. Where such invasion results in substantial harm to the patient, as in the \textit{Dray}, Valdez, Paulsen, Bonner, Wall, Maercklein and \textit{Franklyn} cases, there seems great justification for a

\textsuperscript{121} Higley \textit{v. Jeffrey}, 44 Wyo. 37, 8 P.2d 96 (1932).
\textsuperscript{122} Barnett’s \textit{Adm’r v. Brand}, 165 Ky. 616, 177 S.W 461 (1915).
\textsuperscript{123} Delahunt \textit{v. Finton}, 244 Mich. 226, 221 N.W 168 (1928).
doctrinal classification of the conduct as "assault and battery." When, however, there is no substantial showing that the conduct of the defendant has actually caused any harm to the patient other than the infliction of incidental pain and suffering, which probably is no greater than that which would result from the consented-to operation or from continuation of the patient's infirmity, and where the treatment in point of fact may have benefited the patient by removing a source of greater illness in the future, as in Mohr, Hively, Reddington, Pratt, Wells and Tabor, the designation of the defendant's conduct as an "assault and battery" seems justified primarily in terms of protecting the patient's interest in making his own decisions as to what operations shall be performed. The same seems to be true in a case like Nolan v. Kechjian, where there is no serious harm and perhaps no serious deviation from the terms of the consent. In the cases where the patient has come to the doctor with the primary objective of obtaining relief from his infirmity, as in most of the cases of abdominal surgery, and where the nature of the infirmity cannot be readily determined prior to the operation itself, there is less reason to say that the doctor has acted "intentionally" in invading an interest of the plaintiff-patient, inasmuch as there may be some question as to just what was the scope of consent. This certainly seems arguable in cases such as King v. Carney, Russell v. Jackson, Wheeler v. Barker, Zoterell v. Repp, Adams v. Boyce and McGuire v. Rix, although in those cases the courts rely more on a broad interpretation of consent. The argument might also be applied in Pratt, Wells and Tabor, where the patient's lack of actual consent is a bit clearer, or in Church v. Adler, In re Johnson's Estate, Slater v. Baker & Stapleton and Boydston v. Giltner, where there is no showing of any real harm resulting from the defendant's deviation from consent and the courts look instead to whether the defendant conducted himself in accordance with the standards of the profession. In cases where an emergency has arisen due to a condition of the patient's body which was not foreseen at the time of obtaining consent, the courts have adopted an approach of giving the doctor broad discretion. Where the conduct of the defendant is designed to remedy an emergency arising during the operation through no fault on the part of the doctor himself, the designation of the defendant's conduct as an assault and battery appears to serve little or no purpose, since the ultimate decision as to whether he will be liable or not is likely to be made on the basis of what a reasonable physician would do under like circumstances. All of this suggests that a re-evaluation
of the proper classification of these situations might be made, but such reappraisal will be deferred until the last portion of this study.

Mistake in Operations

A third general category into which cases involving unauthorized operations or medical treatment may fall is that of mistake, the situation in which the doctor believes that he is remaining within the terms of the patient's consent but fails to do so through inadvertence.

Typical of this classification are the cases involving the extraction of teeth. Throne v. Wandell, involved a patient who had been sent to the defendant dentist by her regular dentist for the purpose of having an X-ray made of her teeth. The regular dentist had marked the teeth which he wanted X-rayed on a chart which bore the legend, "Kindly mark teeth to be extracted." The defendant removed the teeth instead of X-raying them. The court permitted the patient to recover on an assault charge. In Ehlen v. Burrows, the court treated the removal of sound teeth as an "assault," but said that the cause of action fell within the same statute of limitations as that for negligence. In a later case in California in which the patient alleged both negligence and assault, it was held that the trial court could properly charge on both counts although an unauthorized operation such as removal of sound teeth would be an assault and "negligence has nothing to do with it." On the other hand, in Hershey v. Peake, the court classified the removal of sound teeth as negligence rather than an intentional wrong. The dentist in that case was instructed to remove three teeth from the patient's upper left jaw but instead pulled the corresponding teeth in the upper right jaw. The court said that in this situation the dentist had merely "neglected to use reasonable and ordinary care and skill and carelessly disregarded the knowledge he had obtained from the examination of the X-ray photograph and his own examination of plaintiff's jaw." In accord are McClees v. Cohen and Krompolz v. Hyman, although in the latter the court does say that the situation is one which might be classified as "wanton recklessness." And where the dentist testified that he removed the teeth because he reasonably believed that they were diseased, the court said that although there was no evidence of negli-

124. 176 Wis. 97, 186 N.W. 146 (1922).
125. 51 Cal. App. 2d 141, 124 P.2d 82 (1942).
128. Id. at 565, 223 Pac. at 1114.
129. 158 Md. 60, 148 Atl. 124 (1930).
gence or "malpractice," the question of whether the defendant had removed the sound teeth with or without the consent of the plaintiff would be a question of fact for the jury,\(^{131}\) and by implication, a finding of no consent would be treated as establishing an assault and battery.

In *Samuelson v. Taylor*,\(^ {132}\) the doctor appears to have confused the plaintiff with some other patient and as a result gave a treatment which might have been reasonable for the other patient but which caused infection in the plaintiff's antrum. The court said that liability would be predicated on treating the plaintiff under a mistake in identity. *Gill v. Selling*\(^ {133}\) presented much the same problem, the patient being subjected to a spinal tap which was unnecessary for her but which should have been given to another patient. The court spoke in terms of negligence in subjecting the patient to such unnecessary treatment, although it seems clear that there was no consent to the treatment since the patient did not comprehend what was being done. In *Necolayff v. Genesee Hospital*,\(^ {134}\) the court allowed recovery by a patient who had been given a blood transfusion intended for another patient, which resulted in chills and eventually mental disease. The court said that this was at least negligence and possibly as assault.

In *Sullivan v. McGraw*,\(^ {135}\) the doctor operated on the wrong leg, apparently as a result of some confusion as to which leg was in fact diseased. The patient brought action, phrasing his complaint in terms of negligence. The court affirmed recovery on this theory. In *Moos v. United States*,\(^ {136}\) the plaintiff had entered the Veterans' Hospital for the purpose of having surgical work done on his left leg which had been injured in military service. Plaintiff alleged in his complaint that while he was anaesthetized the hospital's employees "negligently transferred the situs of the operation and operated upon the right leg and hip of the plaintiff," to which operation he had given no consent. The United States District Court in Minnesota dismissed the complaint brought under the Federal Tort Claims Act on the ground that the operation constituted an assault and battery and not merely negligence,\(^ {137}\) although the court recog-

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\(^{132}\) 160 Wash. 369, 295 Pac. 113 (1931).

\(^{133}\) 125 Ore. 587, 267 Pac. 812, 58 A.L.R. 1556 (1928).

\(^{134}\) 286 N.Y. 936, 73 N.E.2d 117 (1947).

\(^{135}\) 118 Mich. 39, 76 N.W. 149 (1898).


\(^{137}\) 28 U.S.C. § 2680 (1952) specifically excludes from the coverage of the Federal Tort Claims Act, "any claim arising out of assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, misrepresentation, deceit, or interference with contract rights."
nized that a claim of negligence might also have been made. The court relied on *Mohr v. Williams*, *Wall v. Brim* and *Bonner v. Moran*. The decision was affirmed by the Eighth Circuit.\(^{138}\) It has been pointed out elsewhere in this Review that the words "assault and battery" probably were inserted as an exception to the Tort Claims Act to exclude liability for deliberate attacks upon plaintiffs and could be interpreted as not covering the present situation.\(^{139}\)

It has long been accepted torts doctrine that where the defendant acts with the intent to accomplish a result which constitutes an invasion of the interests of the plaintiff, he will not be excused by mistake.\(^{140}\) It is also well established that the intent to cause a certain physical consequence rather than the intent to cause harm or injury is the critical factor.\(^{141}\) Therefore, where a doctor performs an operation or renders treatment which he knows if not consented to will constitute an invasion of the patient's right to be left alone and which is in fact harmful, there seems to be sufficient basis for characterizing his conduct as a battery. Yet in such cases as *Hershey v. Peake*, *McClees v. Cohen*, *Gill v. Selling*, *Necolayff v. Genesee Hospital* and *Sullivan v. McGraw*, the courts talk primarily in terms of negligence and lack of due care on the part of the doctor. Where the patient has in fact consented to some operation, as in the *Hershey*, *McClees* and *Sullivan* cases, it may be argued that the real basis for complaint is the doctor's failure to take proper care in determining what should be done. But where, as in *Gill* and *Necolayff*, there is a mistake as to the identity of the patient, this argu-

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138. 225 F.2d 705 (8th Cir. 1955).
141. See Prosser, Torts 29 (2d ed. 1955), Restatement, Torts §§ 13, comments d and e, 16, 18, comment h, 20 (1934).
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ment loses its weight. Perhaps these courts are influenced by the fact that the patients were conscious at the time and may have acquiesced in the treatment, although a persuasive case could be made for the proposition that the patient in each of these cases was not fully cognizant of what was occurring and can hardly be considered to have consented understandingly.

One other type of mistake relating to operations remains to be mentioned. This is a mistake in diagnosis. In most of the cases discussed in this article, the patient’s major concern is in being cured. His or her consent to specific treatment is apt to be based upon the diagnosis of the doctor as to what is the nature of his infirmity and what steps are necessary to correct it. In many of the cases there appears to have been an erroneous diagnosis. In a few of them, the patient has specifically charged the doctor with negligence in diagnosis. Where there has been a mistake in diagnosis the limitations on consent are likely to be a reflection of this error. If this situation is evident from the facts of the case before it, a court may take one of two positions: (1) It may say that the patient has consented to such treatment or operation as will cure his infirmities and that the diagnosis is part of such treatment.


Therefore, unless there is actual negligence in the diagnosis the patient has no basis for complaint. (2) It may say that the patient is entitled to make his own decisions as to what shall be done with his body and to make these decisions on the basis of correct facts. Therefore, when the doctor discovers that his diagnosis is incorrect he should obtain the consent of the patient if this is practicable. Under this latter theory, the fact that the unforeseen condition threatens serious harm to the patient and that there is a necessity for immediate action, or the seriousness of the shock of a second operation, may justify the doctor in acting without obtaining express consent. These two arguments may apply equally to the situations in which there has been express prohibition, to the extent that the prohibition is based on inadequate knowledge of the facts by the patient.144

A REAPPRAISAL OF THE LAW OF UNAUTHORIZED OPERATIONS

This study of cases involving unauthorized operations or medical treatment indicates the existence of a great diversity of factual situations ranging from a case such as Schloendorff v. Society of New York Hospital, in which the doctor operated in direct violation of express prohibitions of the patient and the operation resulted in serious physical injury, to cases such as Mohr v. Williams or Pratt v. Davis, in which the operation was done without the express consent of the patient but probably caused no serious harm to the patient and in point of fact may have conferred some benefit. Between these two extremes lie cases in which there was only a limitation upon a general scope of consent the violation of which did not seriously injure the patient, as in Rolater v. Strain, and cases in which there was no express prohibition but substantial harm resulted to the patient from an operation which went beyond the scope of express consent, as in Wall v. Brim or Paulsen v. Gunder- sen. Yet the courts tend to group together all of these diverse fact situations under the category of “assault and battery” and rely upon any one of the early cases as authority for imposing liability upon the doctor which may differ substantially from the nature and scope of liability in a general malpractice action.145 At the same time, some courts have broken away from this categorization of the unauthorized operation and have treated it as “malpractice” for the purpose of applying a general statute of limitations rather than

145. See discussion pp. 383-84 supra.
the shorter statute normally applicable to assault and battery claims; and occasionally a court has suggested that a doctor might be excused from liability in such a case upon a showing of good medical practice, though this is anything but uniform.

This apparently inconsistent application of theory and the possibility of some inequity in classifying the attempts of a physician or surgeon to render reasonable assistance to a patient by the onerous title of "assault and battery," led the present author to a reappraisal of the law to be applied in these varied situations. The main thrust of this reappraisal was to see whether all of the malpractice claims could not be judged by the same standard, i.e., has the defendant doctor compiled with the standard of care established by the practice of a reasonable and ordinary doctor under similar circumstances?

Traditionally the distinction between an "assault and battery" and a "negligent tort" has been drawn on the basis of the existence or nonexistence of "intent," that state of mind in which the actor acts for the purpose of accomplishing a given consequence or acts with knowledge that such a consequence is substantially certain to occur, although there need be no showing of a hostile or malicious purpose or of an intent to do harm. In all of the cases discussed in this article, the physician knew what he was doing; he knew that he was performing a certain operation or that he was rendering certain treatment affecting the body of the patient. In all but a few of the cases it is to be inferred that he also knew that there was no specific assent to such operation or treatment, and in some of those few the lack of such knowledge was the result of mistake as to the identity of the patient or the identity of a particular portion of the body to be treated, neither of which would constitute a defense. In each of the cases there has been a legal "harm" in the sense of a physically harmful invasion of the body of the plaintiff.


patent or an interference with the patient's personal integrity or right to determine what shall and shall not be done with his body. Following these traditional lines of analysis, one would conclude that except in a very rare case, such as a true emergency, the doctor who acts without the consent of the patient is guilty of an assault and battery.

What appears to distinguish the case of the unauthorized operation from traditional assault and battery cases is the fact that in almost all of the cases, the doctor is acting in relative good faith for the benefit of the patient. It is true that in some cases the results are not in fact beneficial, but the courts have stated repeatedly that doctors are not insurers. The traditional assault and battery, on the other hand, involves a defendant who is acting for the most part out of malice or in a manner which is generally considered as "anti-social." And in general the assaulter and batterer is not seeking to confer any benefit upon the plaintiff, even though he may believe, as Dean Prosser has suggested, that he is complimenting the plaintiff by his amatory advances. This leads to the conclusion that there is some basis for separating most of the cases discussed in this paper from the traditional assault and battery. At the same time, there appears to be justification for retaining the "assault and battery" classification for such situations as occurred in *Bryan v. Grace, Wellman v. Drake* and *Keen v. Coleman,* as well as the "fraud" cases. Operations, declared to be anti-social in their very nature by statutes making their performance a crime, deserve specialized treatment.

Support for the proposition that an unauthorized operation should not be treated as an assault and battery, may be found in such cases as *Hershey v. Peake,* in which the doctor had removed sound teeth instead of diseased teeth without any evidence appearing which would explain such an error. In that case the court said, "The fundamental distinction between assault and battery on the one hand and negligence such as would constitute malpractice, on the other, is that the former is intentional and the latter unintentional," and then proceeded to classify the conduct of the defendant as negligent only. Such classification might be explained on the ground

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149. See cases cited note 7 supra.
151. These cases are discussed pp. 393-94 supra.
152. These cases are discussed pp. 394-95 supra.
153. These cases are discussed p. 395 supra.
155. Id. at 565, 223 Pac. at 1114.
that the question before the court was the applicability of a one year statute of limitations for assault and that the court was motivated by a desire to give the patient as full protection from this sort of misconduct on the part of a doctor or dentist as would occur if there were mismanagement of a drill. The same distinction has been made in a case involving a doctor's intoxicated attempt to remove a catheter from a patient's bladder over the protest of the patient.156 The patient alleged in his complaint that the doctor was so unsteady on his feet that he fell and tore the catheter from the patient's body. The court treated the entire episode as one of negligence, in spite of the fact that there had been express protest and serious harm resulting to the patient. In a third case the patient alleged, and the court agreed, that there had been no consent to an operation upon her esophagus in the course of which the esophagus was punctured.157 The court treated this as negligence, saying:

... we believe that a reasonable interpretation of the term "assault and battery," as used in the policy provision quoted, is that it means a wilful or intentional, an unlawful or criminal, act of violence, not an incident such as we have here where, obviously, failure to obtain the patient's consent was due to inadvertence. .. All doctors know they should have their patient's consent to an operation or render themselves liable, and no sensible practitioner would deliberately expose himself to such a risk. . . . In this case failure to obtain the patient's consent was unintentional. It was a mere oversight. It did not constitute "assault and battery." It was an act of malpractice, and, in our judgment, it was covered by the policies.158

The court was interpreting a policy of malpractice insurance and perhaps the interpretation most favorable to the insured and least favorable to the company justifies this apparent rejection of the weight of authority. It may be that in other circumstances, where the action is between patient and doctor individually and the doctor seeks to establish that what he did was in accordance with well-recognized medical practice, the court will withdraw from this position. But until such withdrawal is clear, the court's opinion, together with the two earlier ones and others dealing with the problem of the statute of limitations tend to support treatment of all malpractice actions alike. Although the objection may be made to reliance upon these cases that they were all decided most favorably for the patient, it should be noted that some courts in classifying unauthorized

158. Id. at 6.
operations adopt terminology which would not be most favorable to the patient.\textsuperscript{159}

It may be argued that to adopt a standard of conduct of the established practice of medicine and surgery is to deny recovery in most of the cases mentioned, since the repeated instances of unauthorized treatment indicate that this may be customary and accepted practice. Furthermore, it may be argued, to adopt such a standard is to deny protection to the right of the patient to have his body secure from any and all unconsented-to touching, a right which has been recognized by the common law for generations. One partial answer to this line of argument is made by the court in the \textit{Shehee}\textsuperscript{160} case when it says that no reputable doctor will operate without the patient's consent and then designates such conduct as malpractice. But more than this, the author believes that the serious peril which is foreseen by the hypothetical arguer does not really exist for two reasons.

(1) Without having any actual proof, the author believes that a good many of the cases involving unauthorized operations are brought by patients who have discovered that the cure which they believed would result has not occurred, or a case may be brought by a patient who has lost what he believes to be a vital organ but which in fact is either functionless or diseased.

(2) An additional, and more likely, reason for such actions appears to be a lack of communication between doctor and patient, that is, the doctor frequently has failed to explain to the patient the real meaning of a medical term, or the danger involved in a particular operation, or the danger of continued existence of certain conditions of the body. This latter reason may apply not only to those cases in which the lack of authorization is based on a material

\textsuperscript{159} In Cady v. Fraser, 122 Colo. 346, 276 Pac. 30 (1924), the court indicated that there could never be an assault and battery charge where there was any contractual relation between the doctor and patient, without making it clear that deviation from the terms of the contract would be anything more than negligence. This was followed by Maercklein v. Smith, 129 Colo. 72, 266 P.2d 1095 (1954), discussed at p. 412 supra, in which the court treated the case as one for “negligence” and specifically said that it was not clear whether there had been sufficient deviation from the express terms of the contract to constitute negligence, although the fact situation seems to fit the “assault and battery” category as stated in other cases. In Marshall v. Curry, (1933) 3 D.L.R. 260, 60 Can. Crim. Cas. 136 (Nov. Scot. Sup. Ct. 1933), the court stated that if the doctor were not justifiably excused by an emergency situation the claim of the patient would be barred by the statute of limitations applied to assault and battery actions, rather than relying on the longer period of limitations for general negligence which would normally apply to malpractice actions.

change in the character of the operation, as in *Wall v. Brim* or *Paulsen v. Gundersen*, but also may be the reason for the patient's claim of lack of authorization where the scope of the operation has extended beyond what the patient believed to be the limits of his consent, as in *Wells v. Van Nort* or *Pratt v. Davis*. In these latter cases it seems likely that the doctor did not fully explain to the patient that there was considerable uncertainty as to the precise nature of the infirmity and that there was some possibility that other organs were diseased.

If the sole basis or reason for bringing an action is the former, *i.e.*, disappointment as to the outcome of the operation, there is no real loss in denying recovery. On the other hand, serious objection may be raised to denying recovery where the reason for bringing the action is failure of communication by doctor to patient. The proper solution of this problem, in the opinion of the author, is to recognize that the doctor owes a duty to his patient to make reasonable disclosure of all significant facts, *i.e.*, the nature of the infirmity (so far as reasonably possible), the nature of the operation and some of the more probable consequences and difficulties inherent in the proposed operation. It may be said that a doctor who fails to perform this duty is guilty of malpractice. This argument has in fact been made in two cases.

In *Hunt v. Bradshaw*, a piece of metal had entered the plaintiff's neck, but had given him little or no trouble. The doctor after making X-ray examinations, advised the patient that the metal was working down through his body and would endanger the heart if not removed. In reply to the patient's inquiry as to whether the operation would be a serious one, the doctor said that there was nothing to it, that it was very simple. It appeared that in fact the location of the piece of metal made it reasonably likely that in the course of operation the blood supply to a certain bundle of nerves might be cut off, which could result in partial paralysis. In fact this occurred. The patient sued alleging negligence on the part of the doctor in not properly advising him of the dangers of the operation, along with other charges of negligence. The appellate court affirmed a nonsuit, saying:

> It is understandable the surgeon wanted to reassure the patient so that he would not go to the operating room unduly apprehensive. Failure to explain the risk involved, therefore, may be considered a mistake on the part of the surgeon, but under the

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facts cannot be deemed such want of ordinary care as to import liability. Of course, it seems hard to the patient in apparent good health that he should be advised to undergo an operation, and upon regaining consciousness finds that he has lost the use of an arm for the remainder of his life. Infallibility in human beings is not attainable. The law recognizes, and we think properly so, that the surgeon's hand, with its skill and training, is, after all, a human hand, guided by a human brain in a procedure in which the margin between safety and danger sometimes measures little more than the thickness of a sheet of paper. The plaintiff's case fails because of lack of expert testimony that the defendant failed, either to exercise due care in the operation, or to use his best judgment in advising it.

In a somewhat older case from Ontario, *Kinney v. Lockwood Clinic, Ltd.*, the patient had come to the defendant doctors to see if they could do anything about a swelling in the palm of her hand. One of the doctors informed her that she suffered from Dupuytren's Contraction and that it would be wise to have an operation. There apparently was some conflict in the testimony, but plaintiff's version was that the doctor informed her that the operation would be a "simple" one, that she would be out of the hospital within three days and would have the complete use of her hand at the end of three weeks. The plaintiff then submitted to the operation, which was unsuccessful. She sued alleging that the operation performed was "serious, precarious and dangerous" and that the defendants had negligently failed to inform her of the nature of the operation. There was some showing that the percentage of success in operations of this type was not overwhelming, and that the disease or infirmity itself sometimes gave no serious trouble to the patient and sometimes moved very quickly to cripple the patient's hand. The trial court gave judgment for the plaintiff, saying

the duty of the defendants was to enlighten the patient's mind in a plain and reasonable way as to what her ailment was, as to what were the risks of operating promptly, what were the risks of delaying the operation, and what the risks of not operating at all. Having discharged that duty, it was the duty of the surgeons to secure from the patient a decision or consent as to what course was to be followed, and if that decision or consent is not had and the surgeons operate in a case like this and the operation turns out badly and damages ensue, the surgeons are liable.

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162. *Id.* at 523, 88 S.E.2d at 766.
163. *Id.* at 524, 88 S.E.2d at 766.
164. (1931) Ont. 438, (1931) 4 D.L.R. 906 (Sup. Ct.).
165. *Id.* at 442, (1931) 4 D.L.R. at 907.
On appeal this judgment was reversed. The Court of Appeal (or two of its members) agreed that there should be liability if the doctor had failed to explain the general nature of the operation, but found there was sufficient evidence of such explanation to make a jury question. Two of the judges said that there was no obligation to inform the plaintiff as to the seriousness of the operation or that the disease would or would not progress rapidly so long as the doctors themselves did not have a firm belief on these subjects. The court did not wholly reject the theory of a duty of disclosure, however, since one of the judges concluded:

The relationship between the defendant Stoddart and the plaintiff was that of surgeon and patient, and as such the duty cast upon the surgeon was to deal honestly with the patient as to the necessity, character and importance of the operation and its probable consequences and whether success might reasonably be expected to ameliorate or remove the trouble, but that such duty does not extend to warning the patient of the dangers incident to, or possible in, any operation, nor to details calculated to frighten or distress the patient.

The dissenting judge supported the trial court's opinion.

It should be noted that both of these cases raise the point that although the doctor may have some obligation to disclose facts to the patient, the possibility of creating fright or nervous tension on the part of the patient may deter him from making a detailed disclosure. Another qualification may be that a good deal of what might go into a diagnosis and prognosis of a case can hardly be classified as "fact" and lies largely in the realm of supposition, or hunch based on experience. Some question may be raised as to the extent to which the doctor should be under an obligation to discuss such conclusions with the patient and whether he can intelligibly communicate the significance of certain "facts" or the weight to be given certain conclusions without giving a short course in medicine and surgery. Some of the difficulties inherent in imposing any such duty have been discussed elsewhere.

At this point some reference should be made to a recent symposium review of Dr. Joseph Fletcher's book, *Morals and Medicine*. Dr. Fletcher emphasizes, particularly in the chapter, "Medi-

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167. Id. at 160-61, (1932) 1 D.L.R. at 525.

168. See, e.g., Lund, The Doctor, the Patient and the Truth, 19 Tenn. L. Rev. 344 (1946), Smith, Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness, 19 Tenn. L. Rev. 349 (1946).

cal Diagnosis Our Right to Know the Truth," the right of the patient to be informed as to the nature of his illness and to make decisions for himself. It is significant that all six commentators on the book and on this particular point agreed that the patient has a "right" to know the truth, but almost uniformly doubted that such a right should be subject to legal enforcement. This attitude of reluctance toward legal remedies apparently grows out of doubt as to whether anyone can objectively establish "the truth" or "the facts" in medical cases and doubt as to the practicability of administration of legal obligations to tell all. Some of this doubt may rise from the fact that the major emphasis is placed on the question of whether the doctor need tell the patient the "truth" about the imminence of death. The commentators, and Dr. Fletcher himself, do not address themselves to the particular problem before us, i.e., whether the doctor has an obligation to explain to the patient in language as simple as necessary the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results or unforeseen conditions within the body. It would appear that the administration of such an obligation, by imposing liability for malpractice if the operation were performed without such explanation where explanation could reasonably be made, would not present insurmountable obstacles. This is particularly true if one considers that a good number of the cases involving the question of consent probably turn on the extent to which the patient was informed of the nature of the operation and then submitted to it.

Even though a combination of a presumption that no reputable doctor would operate without his patient’s consent and an obligation on the part of the doctor to make reasonable disclosure to the patient in obtaining that consent may meet the argument that the adoption of a "reasonable doctor" standard for all malpractice cases.

170. The six participants in the symposium, in addition to Professor Thomas Cowan of Rutgers University Law School, who wrote the introductory materials, were: Horace M. Kallen, Research Professor in Social Philosophy and Professor Emeritus of the Graduate Faculty of Political and Social Science, New School for Social Research, "An Ethic of Freedom: A Philosopher’s View," id. at 1164; Rev. Joseph D. Hassett, S.J., "Freedom and Order Before God: A Catholic View," id. at 1170; Paul Ramsey, Professor of Religion, Princeton University, "Freedom and Responsibility in Medical and Sex Ethics: A Protestant View," id. at 1190; Rabbi Emanuel Rackman, "Morality in Medico-Legal Problems: A Jewish View," id. at 1205; I. Phillips Frohman, M.D., "Vexing Problems in Forensic Medicine: A Physician's View," id. at 1215; Harry Kalven, Jr., Professor of Law, University of Chicago, "A Special Corner of Civil Liberties: A Legal View I," id. at 1223; Morris Ploscowe, Member of New York Bar and Former New York City Magistrate, "The Place of Law in Medico-Moral Problems: A Legal View II," id. at 1238.
would permit wholesale operation without consent, there remains the point that this will undermine the patient's long established right to have his body secure from unwanted touching. One simple answer to this argument would be that in the large majority of these cases the patient has submitted himself to some touching by the doctor and that if all that is being protected is his personal dignity the countervailing policy of allowing the doctor reasonable discretion in using his skill for the benefit of the patient would appear to justify doing away with "assault and battery" charges. Where there has been a total lack of consent, as in Schloendorff or possibly Physicians' and Dentists' Business Bureau v. Dray,¹ it seems highly unlikely that there will be much question as to whether this is "reasonable" or "proper" medical practice. Furthermore, if the liability of the doctor should include punitive character, this may be achieved by terming this particular conduct "wanton," "recklessness" or some other appropriate epithet which will designate an extreme deviation from the normal standard, assuming that this is, in the mind of the trier of fact, such an extreme deviation. Between these two extremes are the situations in which there has been some harm resulting from an operation which goes outside the scope of the express consent or violates some limitations placed on a general submission to the doctor's care. Here the balancing of the interest in protecting doctors in the exercise of professional discretion and the interest of protecting personal integrity of patients may be left to the trier of fact. One factor which the trier of fact will have to consider in making this determination in a particular case, is whether the personal integrity being protected is a somewhat unrealistic right in view of the probability that the patient does not have the capacity to make intelligent decisions on many questions of medicine and surgery and in general has entrusted himself to the doctor's care. This is not to suggest that it may not be appropriate for the patient to impose limitations on the nature of the operation and such items as the use of spinal or general anaesthetic, but it is intended to raise the question of whether Miss Strain, if asked prior to the operation whether the doctor might remove a non-functional bone in order to drain the infection in her great toe, would have remained adament in her requirement that no bones be removed. This proposition assumes that doctors are generally to be trusted not to engage in dangerous operations or treatment without the consent of the patient and that the doctor is exercising his skill for the benefit of the patient. But inasmuch as this assumption

¹ 8 Wash. 2d 38, 11 P.2d 568 (1941), discussed at pp. 405-06 *supra.*
is a basic tenet of medical science it seems a proper one.

One major difficulty remains, and it may well be a decisive one in a reappraisal of the law on this subject. The difficulty is the question of proof. Who is to determine what is reasonable and prudent medical practice? In cases such as Moos v. United States or Schloendorff v. Society of New York Hospital, the deviation from the standard may be sufficiently obvious so that the jury may determine liability without reliance upon medical expert witnesses. And in a case such as Jackovach v. Yocum,172 where the patient was unconscious and his life was threatened if immediate action was not taken, or Delahunt v. Finton,173 where an instrument became trapped inside the body, the jury may determine that any reasonable doctor would act without consent for the benefit of the patient. But in such cases as Mohr v. Williams or Tabor v. Scobee,174 there may be technical questions as to the need for immediate action and the risks of delay or the effect of shock of a second operation which will require medical expert testimony. There is considerable support for the proposition that medical expert testimony is most difficult to obtain in malpractice cases, particularly testimony favorable to the plaintiff.175 The reasons for hesitancy on the part of doctors have been explored recently by several authorities.176 Such problems as the expense in time and money of testifying and the reluctance of doctors to subject themselves to the ordeal of cross-examination may be overcome by greater cooperation on the part of both the medical and legal professions in establishing fair witness fees and making provisions for calling medical witnesses at times which will be reasonably convenient for both the witness and the court.177 One

172. 212 Iowa 914, 237 N.W. 444, 76 A.L.R. 551 (1931)
174. 254 S.W.2d 474 (Ky. 1952), discussed p. 410 supra.
177. Some work in this area has been done through the drawing up of a proposed Code of Inter-Professional Conduct, by a joint committee of the Bar Association and Medical Associations of Ramsey County, Minnesota. See also 26 Cleveland B.A.J. 167 (1955), 28 Wis. B. Bull. 10 (Aug. 1955) for reports of similar activity in other states.
problem which is not emphasized by the Villanova survey on why doctors are unwilling to testify, but which the present author believes plays a large part in developing such unwillingness on the part of many doctors, is the difficulty of defining what is "reasonable and proper medical practice." Where the defendant doctor has not committed an obvious violation of the medical standards of conduct, many doctors appear to be unwilling to criticize what may prove in the long run to be proper practice. There is sufficient variation in methods of treatment and operation, and sufficient difficulty in describing in words the actual conditions obtaining at the time of the operation so that doctors may themselves be uncertain as to what they would do under the circumstances. Perhaps the answer is to allow the medical witnesses to make as complete examinations of the patient, the hospital records and reports of the operating surgeon as they feel are necessary and then permit them wide leeway in preparing their testimony and delivering it without interruption by counsel in the form of questions and objections until the report is given. Perhaps more reliance on "neutral" witnesses appointed by the court, with the approval of both parties, will tend to solve some of these problems. Two other existing solutions to the problems deserve mention: the "Minnesota plan" whereby questions of deviations from the truth by medical witnesses are referred to special committees of the medical and legal professions, and the use in Massachusetts and Nevada of medical treatises as a substitute for the medical witness. Mr. Melvin Belli has recently raised still another question, that of the influence of malpractice insurance companies in deterring doctors from taking the stand.

The ultimate solution of this question, along with the others raised here, will depend on the combined efforts of the two professions, but does not seem an impossible goal.

Pending such solution, it may be possible to give the protection necessary to plaintiffs by imposing a burden upon the defendant doctor to come forward with an explanation of his conduct where

179. This is possible under such statutory provisions as Cal. Code Civ. Proc. Ann. § 1871 (West 1955).
the plaintiff has shown that the operation exceeded the scope of consent. Such a "presumption" probably has sound basis in the normal practice of doctors of not performing operations without obtaining consent.

Conclusion

As a general proposition, it may be said that when a doctor undertakes to perform an operation or render medical treatment to a patient, without first having obtained the understanding consent of the patient, he will be treated as having committed an assault and battery. There are, however, provisions for emergency treatment, and a large number of courts have varied from the "assault and battery" classification in applying the statute of limitations. The cases in which this problem of classification and imposition of liability have arisen present a wide variety of factual problems some of which deserve severe treatment, others of which appear to be little more than a minor deviation from the standards of good practice if that.

The author concludes that the trial and decision of these unauthorized operation cases would be greatly improved in terms of consistency of theory and appropriateness of liability if there were a single basis for liability in all malpractice cases, other than the occasional instance of an actual assault and battery in the sense of an intentional deviation from practice which does not tend to be beneficial to the patient. The basis of liability should be deviation from the standard of conduct of a reasonable and prudent doctor of the same school of practice as the defendant under similar circumstances. The author believes that under such a standard the patient will be properly protected by the medical profession's own recognition of its obligation to maintain its standards. One particular obligation which the law may properly exact or impose, however, is the obligation of a doctor to make a reasonable disclosure to the patient of the nature of his illness or infirmity, the nature of the treatment proposed and the danger of using such treatment or alternative treatment, and then permit the patient to decide whether to submit to the treatment or not. To overcome any difficulties of proof, the law may also properly create a presumption that where the patient has not given express consent to the operation or treatment, there has been a deviation from the standard of proper medical care, which presumption will impose upon the doctor the onus of coming forward with justification of his conduct by the use of qualified medical evidence.