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PHYSICIANS AND SURGEONS— LIABILITY FOR UNAUTHORIZED TREATMENT

I. INTRODUCTION

The scope of this note is limited to indications of various circumstances which result in liability of the physician or surgeon for unauthorized treatment. It will indicate different rules and concepts developed by the courts in dealing with such problems.

The limitations of such concepts and rules will be shown as serving to discourage the physician or surgeon from administering treatment under certain conditions.

II. CONSENT

Common law required the patient's consent when authorizing a physician to administer treatment, for the patient was a conscious participant.[1] The underlying principle is that the unauthorized touching of another's person constitutes a trespass, resulting in liability.[2]

However, the use of anesthetics has modified the common law concept of consent. The patient is no longer a conscious participant in the operation and thus, is unable to give his consent when it may be required.[3] Today, the commencement of an operation occurs when the anesthetic is administered or when it takes effect on the patient.[4]

The general rule is that consent of the patient is required for treatment or surgery. Therefore the physician or surgeon who administers treatment or operates without the patient's consent, express or implied, subjects himself to liability.[5]

A. MINORS—The parent's consent for treatment of a minor is required except in an emergency or exceptional circumstances.[6] Moreover, temporary custody of a child by someone other than parents will not constitute authority necessary to

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1. See Bennan v. Parsonnet, 83 N.J.L. 20, 83 Atl. 948 (1912); Kennedy v. Parrott, 243 N.C. 355, 90 S.E.2d 754 (1956).
2. PROSSER, TORTS § 18, at 82, 83 (2d ed. 1955).
3. McGuire v. Rix, 118 Neb. 434, 225 N.W. 120 (1929); Kennedy v. Parrott, 243 N.C. 355, 90 S.E.2d 754 (1956).
4. See **e. g.,** Bennan v. Parsonnet, 83 N.J.L. 20, 83 Atl. 948 (1912).
5. Chambers v. Nottebaum, 96 So. 2d 716 (Fla. 1957); Rogers v. Lumbermens Mutual Casualty Co., 119 So. 2d 649 (La. 1960); Bang v. Charles T. Miller Hospital, 251 Minn. 427, 88 N.W.2d 186 (1958); Nolan v. Kechijian, 75 R.I. 165, 64 A.2d 866 (1949); **In re** Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942).
6. Bonner v. Moran, 126 F.2d 121 (App. D.C. 1941); Zoski v. Gaines, 271 Mich. 1, 260 N.W. 99 (1935); Sullivan v. Montgomery, 155 Misc. 448, 279 N.Y.S. 575 (1935); Moss v. Rishworth, 222 S.W. 225 (Tex. 1920).

preclude liability for performing an operation.[7] *The Restatement of Torts*[8] takes a more liberal view in reasoning that if a child is capable of understanding the nature, extent, and consequences of the treatment or operation, his consent alone will constitute sufficient authorization although the parents expressly refuse their consent. That argument has been criticized as overlooking the infancy exception, requiring legal protection for the personal and property rights of minors.[9] Where the operation is for the benefit of another person consent by a minor is not sufficient.[10]

The decisions finding liability where parental consent is lacking are unnecessarily rigid today. Where the minor is able to understand the nature and consequences of the treatment, his consent should suffice; that is, as long as the treatment is for his own benefit, and is not in the face of an express refusal by his parents.

B. THE PHYSICIAN AS LEGAL REPRESENTATIVE AND GENERAL AUTHORIZATION—Some courts have considered the physician as the legal representative of the anesthetized patient if there is no other person to act in behalf of the patient.[11] Such representation applies only to the general lines of treatment agreed upon.[12]

Another theory advanced is that where a patient has voluntarily submitted to diagnosis and treatment, a general authorization is given the physician. Consequently, the physician's acts are authorized either expressly or by implication, in absence of evidence to the contrary.[13] Finding a general authorization appears usually to result in a decision for the physician.

C. EMERGENCIES AND UNANTICIPATED CONDITIONS—A physician called to attend a person who is injured and requires prompt medical attention may administer treatment reasonably necessary to preserve the life or health of the patient.[14] The same reasoning is applied where "unanticipated conditions" arise during the course of an authorized operation.

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7. Moss v. Rishworth, 222 S.W. 225 (Tex. 1920).
8. RESTATEMENT, TORTS § 59, comment (a) at 111 (1934).
9. Bonner v. Moran, 126 F.2d 121 (App. D.C. 1941).
10. **Ibid.**
11. See **e. g.,** Franklyn v. Peabody, 249 Mich. 363, 228 N.W. 681 (1930); Bennan v. Parsonnet, 83 N.J.L. 20, 83 Atl. 948 (1912).
12. See **e. g.,** Franklyn v. Peabody, 249 Mich. 363, 228 N.W. 681 (1930).
13. Baxter v. Snow, 78 Utah 217, 2 P.2d 257 (1931).
14. See Pratt v. Davis, 244 Ill. 300, 79 N.E. 562 (1906); Luka v. Lowrie, 171 Mich. 122, 136 N.W. 1106 (1912); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905) (dictum).

Thus, in the event of an emergency or unanticipated condition the physician: (1) has a duty to perform or to do what the occasion demands without obtaining consent;[15] (2) must act on his own discretion;[16] (3) where it is impracticable to obtain consent, may proceed to remedy the condition without consent.[17] It is argued, however, that implied consent under these circumstances is a fiction[18] and that in fact the physician is "privileged" to render treatment.[19]

The area of emergency or unanticipated conditions is the area of greatest controversy regarding unauthorized treatment. It is submitted that no strict rule should be applied here and all circumstances should be weighed before assigning liability. Otherwise an injured person or one requring assistance may not readily receive medical attention.

D. CONSENT FORM—General consent forms have not provided the physician with any substantial measure of protection against liability. Consent forms have precluded liability usually when fortified with some other justification for treatment.[20] A general consent form has been considered to constitute an authorization so ambiguous as to be completely worthless since it failed to designate the nature of the operation for which consent was given.[21] But a signed consent form alone precluded liability for administration of an anesthetic not otherwise authorized.[22] It has been held that the validity of a signed consent form can not be determined by the general law of contracts because of the special physician-patient relationship.[23] Further, a consent form must be signed with complete understanding of the treatment to be performed.[24]

Consent forms may be desirable to indicate the type of treatment or procedure to be administered. However, unless the consent form indicates with reasonable particularity the nature of the treatment to be undergone, it should have no validity.

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15. Danielson v. Roche, 109 Cal. 2d 832, 241 P.2d 1028 (1952); Wheeler v. Barker, 92 Cal. 2d 726, 208 P.2d 68 (1949); Delahunt v. Finton, 224 Mich. 226, 221 N.W. 168 (1928); Kennedy v. Parrott, 243 N.C. 355, 90 S.E.2d 754 (1956).
16. Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).
17. Sullivan v. Montgomery, 155 Misc. 448, 279 N.Y. Supp. 575 (1935).
18. Kritzer v. Citron, 101 Cal. 2d 33, 224 P.2d 808 (1950).
19. PROSSER, TORTS § 18, at 84 (2d ed. 1955).
20. Danielson v. Roche, 109 Cal. 2d 832, 241 P.2d 1028 (1952).
21. Rogers v. Lumbermens Mutual Casualty Co., 119 So. 2d 649 (La. 1960).
22. Moore v. Webb, 345 S.W.2d (Mo. 1961).
23. See Moore v. Webb, 345 S.W.2d (Mo. 1961).
24. Keister v. O'Neil, 59 Cal. 2d 428, 138 P.2d 723 (1943).

E. CONSENT AS A CONTRACT—Another view is that when a patient weighs the dangers and risks incident to an operation and consents thereto, he in effect enters into a contract authorizing the physician to operate.[25] Thus a patient may insist upon strict performance of such contract.[26] Recovery has been permitted on the basis of breach of contract,[27] and for violation of contract as to the manner of operation.[28] Medical treatment has been considered a service, constituting a necessary for which a minor may contract.[29]

But the idea that a surgical operation can be contracted for has been held invalidated as a result of anesthetics.[30] It has also been argued that such an agreement can not constitute a contract since there is no specification of what the surgeon must do.[31] Futher, the physician-patient relationship can not constitute a strict contract, for the patient is under no obligation to follow the physician's instructions.[32]

The concept of consent as a contract has usually been employed to permit recovery by the patient, but not to prevent liability by the physician. It's validity, therefore, is questionable on those grounds alone. I submit the concept ought to be disregarded in its entirety, for it is patently obvious that the requisites of a contract are not present.

III. TREATMENT OTHER THAN AUTHORIZED

A. GENERAL—Liability for treatment without consent accrues when the treatment administered is different from or in excess of the consent given, or involves risks and results not anticipated.[33] *The Restatement of Torts*[34] contends that consent to a particular operation does not authorize a surgeon to perform another operation. It is of no consequence that another operation may be necessary to effect the patient's cure. However, consent may be implied as the result of emergency.

25. See Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905).
26. Rolater v. Strain, 38 Okla. 572, 137 Pac. 96 (1913).
27. Frank v. Maliniak, 232 App. Div. 278, 249 N.Y. Supp. 514 (1931).
28. Perry v. Hodgson, 168 Ga. 678, 148 S.E. 659 (1929).
29. Bishops v. Shurly, 237 Mich. 76, 211 N.W. 75 (1926). **In re** Dzwonkewicz's Estate, 231 Mich. 165, 203 N.W. 671 (1925).
30. See Bennan v. Parsonnet, 83 N.J.L. 20, 83 Atl. 948 (1912).
31. Kennedy v. Parrott, 243 N.C. 355, 90 S.E.2d 754 (1956).
32. **Ibid.**
33. Wall v. Brim, 138 F.2d 478 (5th Cir. 1943); **In re** Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942) (dicta); Rogers v. Lumbermens Mutual Casualty Co., 119 So. 2d 649, 650 (La. 1960): "The general rule prohibiting the performance of an operation without the consent of the patient extends to the performance of operations different in nature from that for which consent was given, and to operations involving risks and results not contemplated."
34. § 54, comment (a) at 104 (1934).

In the absence of emergency or general authorization, there is no justification for performing an operation not authorized. The physician may not substitute his judgment for that of the patient in the absence of emergency.[35] It does not matter that the operation has been performed with skill and care,[36] or in line with good surgery.[37] Prosser[38] suggests that the physician's "privilege" is limited to acts substantially similar in nature to those authorized. Further, that the physician may not exceed the consent actually given or reasonably to be implied.

For example, a physician was held liable for a thigh operation to obtain tissue needed to remedy an injured finger.[39] But in the extraction of a tooth causing the pain complained of, although not authorized, recovery of damages was not allowed.[40]

Thus, liability has followed where an incision was made deeper than agreed upon.[41] A contrary result was reached, where an additional incision was found necessary to relieve the condition complained of.[42]

It appears that recovery for extension of an operation has frequently been denied where it is necessary to relieve the patient of the ailment of which he has complained. Recovery should be denied whenever the extended operation is of benefit to the patient, and when no detrimental results are experienced by him.

B. MISTAKEN IDENTITY—Occasionally mistake in the identity of a patient has led to the administration of treatment not intended for the patient. In such cases liability has generally followed.[43]

Patients usually do not understand the nature of the treatment to be given. Most patients have implicit confidence in their physicians and questions by the patient are usually not appropriate. Therefore, they cannot be considered to have consented when they acquiesce to treatment given where mistake exists.[44]

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35. Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960).
36. **Supra** note 30.
37. Franklyn v. Peabody, 249 Mich. 363, 228 N.W. 681 (1930).
38. PROSSER, TORTS § 18, at 84 (2d ed. 1955).
39. **Supra** note 40.
40. Doniger v. Berger, 241 App. Div. 23, 271 N.Y. Supp. 30 (1934).
41. **Supra** note 30.
42. Harrison v. Reed, 21 Ohio N.P. (N.S.) 206, 29 O.D.N.P. 399 (1916).
43. Gill v. Selling, 125 Ore. 587, 267 Pac. 812 (1928); Samuelson v. Taylor, 160 Wash. 369, 295 Pac. 113 (1931).
44. Gill v. Selling, 125 Ore. 587, 267 Pac. 812 (1928).

C. MISREPRESENTATION—Liability is incurred if consent for treatment is obtained by representations which are false to the knowledge of the physician.[45] However, the greater problem exists where sufficient information has not been given the patient or, where information has not been conveyed in an intelligible manner. It has been held that a physician violates his duty to his patient by withholding facts necessary to form an intelligent consent.[46] Thus, where alternative situations can be ascertained in advance of an operation and no emergency exists, the patient should be so informed and given an opportunity to decide before the operation.[47]

The rights of a patient when consulting a physician are the right to "diagnosis, advice and consultation". Subsequently, it is for the patient to determine whether treatment is to be administered.[48] A substantial disclosure[49] or a previous full disclosure of implications and probable consequences of the proposed treatment must be given in terms which may be fully comprehended by the patient.[50] Thus, in a recent Kansas decision[51] where radiation therapy was administered with the patient's consent, nonetheless liability arose for injuries resulting. It was reasoned that the nature, risks and consequences of the treatment had not been properly explained. The court further stated that the "informed consent" of the patient must be obtained.[52]

However, complete diagnosis of an internal ailment can not be made until an anesthetic has been administered and an incision made. Therefore, it is unreasonable to hold a physician to the exact operation that his preliminary examination indicated was necessary.[53]

A greater need exists for informing the patient of the nature, risks and consequences of proposed treatment. However, this is not intended to indicate the need for giving detailed technical information. Nonetheless, where an internal operation is involved, both the consent and information relied upon

45. Birnbaum v. Siegler, 273 App. Div. 817, 76 N.Y.S.2d 173 (1948).
46. Salgo v. Leland Stanford Jr. University Bd. of Trust., 154 Cal. 2d 560, 317 P.2d 170 (1957).
47. Bang v. Charles T. Miller Hospital, 251 Minn. 427, 88 N.W.2d 186 (1958).
48. Parmley v. Parmley and Yule, 4 D.L.R. 81 (Can. Sup. Ct. 1945).
49. **Supra** note 38.
50. See Lacey v. Laird, 166 Ohio St. 12, 139 N.E.2d 25 (1956).
51. **Supra** note 38.
52. **Ibid.**
53. See Kennedy v. Parrott, 243 N.C. 355, 90 S.E.2d 754 (1956).

for that consent should be interpreted in the light of conditions subsequently discovered by the physician.

D. SURGERY OR MAJOR OPERATION—Liability for remedying the patient's ailment has been precluded where it is found necessary to resort to surgery, to remove an object from the eye[54] or to reduce a fracture,[55] when authorized methods fail. But liability will follow if a major operation has been preformed and only a minor operation authorized, in absence of emergency.[58] If a diagnosis has been mistaken, the patient if conscious must be permitted to consent to a major operation in the absence of emergency.[57]

If only an examination is authorized, liability may attach when a physician performs an operation.[58] Thus, although a physician claimed the need for clipping tissue to determine a patient's throat problem, liability can be incurred if such clipping is contrary to instructions.[59]

E. REMOVAL OF PART OF THE BODY—Removal of a bone, although serving no useful function,[60] or removal of a gland[61] is not justified, in the absence of authorization. As to the contention that tonsils serve no useful purpose it has been declared:

> The law presumes that every organ, including glands, has some function to perform in maintaining the body in sound health. The presumption is not overcome because medical science has not yet ascertained the precise function performed by a specific organ or gland.[62]

But, a recent Kentucky decision,[63] in *dictum* stated that removal of the appendix on the basis that it has no utility would be permissible without consent.

A patient is entitled to limit his consent to an operation reasonably appropriate to relieve him of his condition.[64] Thus, the removal of an organ is actionable unless, in the course of authorized surgery a condition arises requiring further surgery.[65] But an emergency together with a general consent

54. Adams v. Boyce, 37 Cal. 2d 541, 99 P.2d 1044 (1940).
55. McGuire v. Rix, 118 Neb. 434, 225 N.W. 120 (1929).
56. Paulsen v. Gundersen, 218 Wis. 578, 260 N.W. 448 (1935).
57. Wall v. Brim, 138 F.2d 478 (5th Cir. 1943).
58. See e. g., Physicians' and Dentists' Business Bureau v. Duray, 8 Wash. 2d 38, 111 P.2d 568 (1941).
59. See Marshall v. Harter, 262 S.W.2d 180 (Ky 1953).
60. **Supra** note 28.
61. See Reddington v. Clayman, 334 Mass. 244, 134 N.E.2d 920 (1956).
62. Hively v. Higgs, 120 Ore. 588, 253 Pac. 363 (1927).
63. Nolan v. Kechijian, 75 R.I. 165, 64 A.2d 866 (1949).
64. Valdez v. Percy, 35 Cal. App. 2d 485, 96 P.2d 142 (1939).
65. Wheeler v. Barker, 92 Cal. 2d 68, 208 P.2d 68 (1949).

form has prevented recovery for removal of the uterus, although authorization for removal only of a tumor attached thereto was given.[66]

No liability should follow the removal of a gland or organ where there is medical justification, as long as it is not injurious to the patient. However, such removal on the basis of lack of utility is not justified.

F. UNRELATED CONDITIONS—Frequently the problem of correcting an unrelated condition discovered during the course of authorized surgery arises. Here it is apparently the duty of a surgeon to perform such operation as good surgery demands, although extending the operation further than originally contemplated. This has permitted removal of an acute appendix during an operation for other purposes,[67] and removal of diseased fallopian tubes during an operation to remedy a problem of recurring miscarriages.[68] No liability has resulted for puncturing cysts during an appendectomy on the ground that no express limitation had been placed on the physician.[69] But in the absence of emergency or a condition affecting the patient's life or health, tying off the fallopian tubes created a liability when done without the patient's express consent.[70] The fact that it would have been necessary to remove such organs within six months has been found to be insufficient justification.[71]

A recent California decision[72] has developed a unique rule for the problem of unrelated conditions. There it was held, that if conditions should be discovered that could not reasonably have been anticipated before the operation was commenced, which if postponed would involve pain and distress out of proportion to the risk of a new operation, then the physician is justified in extending the operation. A further stipulation is that the condition must be such that a reasonable man would consent to the operation if he knew of the condition.[73]

The rule which requires correcting an unrelated condition only on the basis of an emergency of safeguarding the patient's life, health or safety should be the only valid reason

66. Tabor v. Scobee, 254 S.W.2d 474 (Ky. 1952).
67. Barnett v. Bachrach, 34 A.2d 626 (App. D.C. 1943).
68. King v. Carney, 85 Okla. 62, 204 Pac. 270 (1922).
69. **Supra** note 33.
70. Murray v. McMurchy, 2 D.L.R. 442 (B.C. Sup. Ct. 1949).
71. See Tabor v. Scobee, 254 S.E.2d 474 (Ky. 1952).
72. Danielson v. Roche, 109 Cal. 2d 832, 241 P.2d 1028 (1952).
73. **Ibid.**

for an extension. In addition, there should be no liability where the extended operation resulted in a benefit to the patient or where no injuries were sustained by him as a result thereof. The view which considers the risk of a new operation in relation to the pain and distress arising out of a postponement has a great deal of merit.

G. INJURIES FROM AUTHORIZED TREATMENT—Occasionally performing authorized treatment, injuries occur which the physician seeks to remedy. It has been argued that reopening an incision to recover a needle does not constitute a separate and independent operation, but is incidental to and a part of the main one.[74] Repairing a fractured jaw as a result of extracting a tooth was held to preclude liability. The reason for not finding liability was the existence of implied consent and the necessity for prompt action.[75] However, another court has held a second operation performed for the purpose of remedying mistakes made in the first operation not justified, for no emergency existed and the patient could have been consulted.[76] On the other hand no liability exists where surgery has not been undertaken to the extent authorized. The reason offered is that the authority to operate carries with it the implied authority not to do so when death would be the most probable result.[77] *The Restatement of Torts*[78] substantiates this in stating that assent to a serious invasion of the person includes assent to a lesser invasion.

There should be no liability for remedying a condition which is a direct result of authorized treatment, nor where an emergency exists, with no opportunity to obtain consent.

IV. CONCLUSION

Greater flexibility in the application of the general consent rule appears desirable. A strict application of the consent rule might often result in a person requiring assistance to be left unattended,[79] and a loss of many lives which might otherwise be saved.[80] More latitude in exercising their judgment should be granted physicians and surgeons. Under modern conditions,

74. Higley v. Jeffrey, 44 Wyo. 37, 8 P.2d 96 (1932).
75. Preston v. Hubbell, 87 Cal. 2d 53, 196 P.2d 113 (1948).
76. Gist v. French, 136 Cal. 2d 247, 288 P.2d 1003 (1955).
77. Huttner v. MacKay, 48 Wash. 2d 378, 293 P.2d 766 (1956).
78. § 54, comment (a) at 104 (1934).
79. See Chambers v. Nottebaum, 96 So. 2d 716 (Fla. 1957).
80. Luka v. Lowrie, 171 Mich. 122, 136 N.W. 1106 (1912) (dictum).

rules of conduct for trained physicians and surgeons should be fixed to reasonably fit conditions. Physicians must be permitted to exercise their professional judgment as to the necessity for treatment without waiting for the consent ordinarily required.[81] Otherwise, the skilled hand of an expert will be stayed by an unreasonable rule, not only detrimental to the patient, but humanity at large.[82]

The concept of the physician as the legal representative of the patient, the general authorization, and the implication of consent, should be discarded. Perhaps even the concepts relating to emergencies and unanticipated conditions ought to be discarded in favor of a more flexible and broader rule. Such rule might be framed on the basis of a "reasonable man" test and could include the viewpoint of both the layman and the medical man. A suggested rule for situations where actual consent is not feasible might be as follows:

> In all circumstances except where there exists an express consent, a physician or surgeon confronted with the treatment of, or an operation upon a patient is not to be found liable for performing such treatment where the circumstances are such that a reasonable man would consent thereto if he were aware of the condition, and where a reasonable physician or surgeon would perform the treatment.

The rule submitted above would provide the courts with more of the flexibility needed to do justice to all parties. It would give the physician or surgeon necessary latitude within which to administer treatment with the view of sustaining and safeguarding lives. Finally, it would safeguard the rights of the patient in the preservation and security of his body.

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81. **Supra** note 62 (dictum).
82. Jackovach v. Yocum, 212 Iowa 914, 237 N.W. 444 (1931) (dictum).