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## Consent to Surgical Procedures

Carl E. Wasmuth, M. D.\*

CASE LAW RELATING TO SURGICAL consent is fairly well settled. A review of the numerous decisions on this question can be summed up with a general statement: If the patient freely consults the physician,<sup>1</sup> understands the operation contemplated, enters the hospital, and submits to the operation, consent is implied.<sup>2</sup> This consent to a surgical operation is a privilege that the patient extends to the surgeon to commit trespass to the person.<sup>3</sup>

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<sup>1</sup> *Bennan v. Parsonnet*, 83 N. J. L. 20, 83 A. 948 (1912).

"A patient who voluntarily consults a surgeon and voluntarily submits himself for treatment, relying entirely upon the surgeon's skill and care to decide for him what shall be done gives a general consent by implication at least, to such operation as may be reasonably necessary."

*Pratt v. Davis*, 224 Ill. 300, 79 N. E. 562, 7 L. R. A. (N. S.) 609, 8 Ann. Cas. 197 (1906).

<sup>2</sup> Held that if a patient voluntarily submits to a dangerous surgical operation, his consent will be presumed unless he is the victim of a false and fraudulent representation; and the burden of proof upon the question of consent is not, therefore, on the surgeon performing the operation.

*State to Use of Janney v. Housekeeper*, 70 Md. 162, 16 A. 382, 2 L. R. A. 587, 14 Am. St. Rep. 340 (1889).

See also, *McClallen v. Adams*, 19 (Pick.) Mass. 333, 31 Am. Dec. 140 (1937);

*King v. Carney*, 85 Okla. 62, 204 P. 270 (1922);

*Baxter v. Snow*, 78 Utah 217, 2 P. 2d 257 (1931);

*Rothe v. Hull*, 352 Mo. 926, 180 S. W. 2d 7 (1944);

*Higby v. Jeffrey*, 44 Wyo. 37, 8 P. 2d 96 (1932);

*Dicenzo v. Berg*, 340 Penna. 305, 16 A. 2d 15 (1940).

"There is no law or statute requiring that signed written authorization be procured from a patient and his spouse preliminary to the performance of an operation and it is not illegal to perform such an operation without first procuring such a signed consent."

*Maercklein v. Smith*, 129 Colo. 72, 266 P. 2d 1095 (1954).

<sup>3</sup> "... and it is settled general rule that in the absence of emergency or unanticipated conditions, a physician or surgeon must first obtain the consent of the patient, if he is competent to give it, or someone legally authorized to give it for him before treating or operating on him."

*Jackovach v. Yocom*, 212 Iowa 914, 237 N. W. 444 (1931). And see

*Schloendorff v. Society of N. Y. Hospital*, 211 N. Y. 125, 105 N. E. 92 (1914).

"... and a surgical operation on the body of a person is a technical battery or trespass unless he or some authorized person consented to it."

*Pratt v. Davis*, 222 Ill. 300, 79 N. E. 562 (1906). And see

One of the basic rights extended to everyone under the common law is freedom from intentional touching of his person.<sup>4</sup> Of course, there are numerous unavoidable trespasses which are a product of modern life. Unintentional touching such as that occurring in a crowded bus or elevator must be expected in our turbulent modern existence.<sup>5</sup> In the casual intercourse of decent society, grasping a friend's arm to attract his attention, although intentional, does not involve a personal indignity. When getting a haircut or having clothes fitted, the touching of the person is intentional but consent is implied. Somewhere beyond these examples, however, intentional touching becomes a battery. It is little wonder that hospital administrators and surgeons exercise such meticulous care to assure the obtaining of authorization for operation before the patient reaches the surgical theater. It would be a stroke of imaginative genius to visualize a more violent trespass to the sanctity of the person than the unpermitted contact of the surgeon's scalpel or the anesthesiologist's syringe of Pentothal.<sup>6</sup>

One court stated: "It is a fact that to anesthetize a human being, to deprive him of consciousness outright, is to take a considerable step along the road to killing him." Granted that this is a dim view of the anesthesiologist's abilities and the patient's chances of survival, it serves as an excellent example of the way a court may scrutinize the physician's activities, especially if they are carried out without the consent of the patient.<sup>7</sup>

Express consent is not always essential, but may be implied or presumed. A patient who voluntarily consults a surgeon and voluntarily submits himself to treatment, relying entirely upon the surgeon's skill and care, gives general consent, by implica-

(Continued from preceding page.)

Mohr v. Williams, 95 Minn. 261, 104 N. W. 12, 1 L. R. A. (N. S.) 439 (1905);

Hively v. Higgs, 120 Ore. 588, 253 P. 363, 53 A. L. R. 1052 (1927).

<sup>4</sup> Prosser, *Handbook of the Law of Torts*, 82 (2d ed., 1955).

<sup>5</sup> Wiffin v. Kincaid, 2 Bos. & PNR 471 (1807);

Coward v. Baddleley, 4 Hur. & Nor. 478 (1859);

McAdams v. Windham, 208 Ala. 492, 94 S. 742, 30 A. L. R. 194 (1922) (boxing);

Gibeline v. Smith, 106 Mo. App. 545, 80 S. W. 961 (1904) (friendly scuffle); Note, 14 Univ. Cincinnati L. R. 161 (1940).

<sup>6</sup> From personal experience.

<sup>7</sup> Hawkins, W. G., *Medicolegal Hazards of Anesthesia*, 163 J. Amer. Med. Assn., 746 (March 2, 1957).

tion at least, to such operations as may be reasonably necessary.<sup>8</sup> When a preoperative diagnosis has not been established, it is accepted surgical practice to perform an explorative operation in order to identify the disease process. In these cases the question often arises as to the legality of radical surgical maneuvers for attempted cures. In cases of malignant tumors in the abdomen, it frequently is necessary to remove entire organs and to radically alter the mechanics of others. If the patient understands the operative procedure, the surgeon acts as his agent and decides for him what shall be done when the true nature of the disease is disclosed.<sup>9</sup> The patient under general anesthesia is unable to grant express consent, but his submission to general anesthesia presupposes that he relies entirely upon the surgeon's skill and judgment. However, such implied consent is extended only to

<sup>8</sup> 41 Am. Jur. 109;

Pratt v. Davis, 224 Ill. 300, 79 N. E. 562, 7 L. R. A. (N. S.) 609, 8 Ann. Cas. 197 (1906);

State to Use of Janney v. Housekeeper, 70 Mo. 162, 16 A. 382, 2 L. R. A. 587, 14 Am. St. Rep. 340 (1889).

A surgeon having full power of control over the hospital nurse administering anesthesia to a patient operated on by a surgeon is bound to exercise such reasonable care and skill respecting administration thereof as is usually exercised by average physicians and surgeons of good standing in the same community as that in which he practices.

Jackson v. Joyner, 236 No. Car., 257, 72 S. E. 2d 589 (1953). And see O'Brien v. Cunard S. S., 154 Mass. 272, 28 N. E. 266, 13 L. R. A. 329 (1891);

Decenzo v. Berg, 340 Penna. 305, 16 A. 2d 15 (1940);

Barfield v. S. Highlands Inf., 191 Ala. 553, 68 S. 30 (1915);

Knowles v. Blue, 209 Ala. 27, 95 S. 481 (1923);

Thebault v. Lalumiere, 318 Mass. 72, 60 N. E. 2d 349, 158 A. L. R. 613 (1945).

<sup>9</sup> "A general direction to a surgeon authorizing him to operate for the cure of a specific physical condition not only authorizes such operation but also authorizes the surgeon to diagnose the case to ascertain for himself the exact cause of the patient's illness and to make preliminary exploratory incisions which may be necessary for that purpose."

Pratt v. Davis, *supra*, n. 8. And see

Baxter v. Snow, 78 Utah 217, 2 P. 2d 257 (1923) (Voluntary submission gives implied consent);

Harrison v. Reid, 21 Ohio N. P. (N. S.) 206, 290 D. N. P. 399 (1916).

*Contra—*

Messlander v. Armstrong, 90 Nebr. 774, 134 N. W. 922 (1912).

"... unauthorized removal of fascia from thigh in order to afford sheathing for the tendons of the finger, could not be justified upon the theory of an emergency since the primary operation on the patient's finger was in no sense a major one."

Franklyn v. Peabody, 249 Mich. 363, 228 N. W. 68 (1930).

"No rule or principle of law (which) would extend to him free license respecting surgical operation."

Mohr v. Williams, 95 Minn. 263, 104 N. W. 12, 1 L. R. A. (N. S.) 439, 111 Am. St. Rep. 462, 5 An. Case, 303 (1905);

Paulson v. Gunderson, 218 Wis. 578, 260 N. W. 448 (1935).

that surgeon whom the patient has consulted, and it is upon that surgeon that the law casts the responsibilities of the agency.<sup>10</sup>

It is generally held that surgical consent is rather general authorization.<sup>11</sup> When the surgeon in the course of an operation (to which the patient has consented) discovers a condition not anticipated, good medical judgment may dictate its correction if possible. This condition, to fall within the consent authorization, however, must be one that endangers the life or health of the patient. Only in such situations is the surgeon justified in extending the surgical procedure.<sup>12</sup> The law in effect assumes that the patient desires all necessary treatment in the judgment of the surgeon. However, there are limits, past which the surgeon exceeds the patient's consent. An authorization for a minor operation ordinarily does not justify performing a major operation<sup>13</sup> that involves risks or results not previously contemplated: this definitely would not be the operation described to the patient

<sup>10</sup> "... he constitutes the surgeon his agent to decide for him what shall be done. . . . the surgeon whom the patient himself selected alone fills the requirements (as his agent), 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 selections."

*Bennan v. Parsonnet*, 83 N. J. L. 20, 83 A. 948 (1912).

"Now with anesthesia, the law will by implication constitute such surgeon the representative pro hac vice of his patient."

*Bennan v. Parsonnet*, 83 N. J. L. 20, 83 A. 948 (1912).

<sup>11</sup> *Bennan v. Parsonnet*, supra, n. 10.

*Baxter v. Snow*, 78 Utah 217, 2 P. 2d 257 (1931);

*Rathe v. Hull*, 352 Mo. 926, 180 S. W. 2d 7 (1944);

*Higby v. Jeffrey*, 44 Wyo. 37, 8 P. 2d 96 (1932).

<sup>12</sup> *Delahunt v. Fenton*, 244 Mich. 226, 221 N. W. 168 (1928);

*Bennett v. Bachrach*, 34 A. 2d 626 (Mun. App. D. C., 1943).

The law should encourage self-reliant surgeons to whom patients may safely entrust their bodies, and hence the law does not insist that the surgeon shall perform every operation according to plans and specifications in advance by patient.

*Kennedy v. Parrott*, 243 N. C. 355, 90 S. E. 2d 754 (1956).

"... that if in the course of the operation to which the patient has consented, the physician discovers a condition not anticipated before the operation commenced, and which if not removed will endanger life or health of the patient, he is, though no express consent be obtained, justified in extending the operation to remove and overcome such conditions."

*King v. Carney*, 85 Okla. 62, 204 P. 270, 26 A. L. R. 1032 (1922).

<sup>13</sup> "Authorization for a minor operation ordinarily does not justify the performing of a major operation which involves risks of results of a kind not contemplated."

*Pratt v. Davis*, 224 Ill. 300, 79 N. E. 562, 7 L. R. A. (N. S.) 609, 8 Ann. Cas. 197 (1906). And see

*Hively v. Higgs*, 120 Ore. 588, 253 P. 363, 53 A. L. R. 1052 (1927);

*Rotater v. Strain*, 39 Okla. 572, 137 P. 96, 50 L. R. A. (N. S.) 880 (1913);

*Zoterell v. Ripp*, 187 Mich. 319, 153 N. W. 692 (1915).

preoperatively. For example, a surgeon may not, on the basis of an unrelated authorization, remove fascia from the thigh in order to repair tendons of the fingers<sup>14</sup> unless it had been explained to the patient that such a secondary operation would be necessary. The lawyer at once recognizes the hesitancy of the courts to permit an injury to an otherwise healthy part of the body in the treatment of another unrelated diseased condition. Consent obtained under fraud or deceit is not valid.<sup>15</sup>

The majority of cases in which the plaintiff charges the surgeon with exceeding consent involve castration.<sup>16</sup> Either the male has a hernia repaired and loses a testicle, or, a woman consents to removal of her appendix and loses her ovary, tube, uterus, or a combination thereof. Although it is difficult to conceive what set of surgical circumstances during repair of a hernia would require castration of the male, there are numerous cases relating to repair of inguinal hernias where the testicle was sacrificed in the procedure. Before an exploratory operation on the female, the surgeon should explain to the woman that it might be necessary to remove some of the generative organs. Some women absolutely refuse to consent to removal of any of the reproductive system even if diseased, and possession of both testicles may be a fetish to a virile male. It behooves all surgeons to explain fully to the patient the intended surgical procedure when it involves removal of generative organs.

It is a well-settled general rule that in the absence of emergency or extraordinary conditions, a surgeon first must obtain the consent of the patient or someone legally authorized to give it for him. A surgical operation without consent is a technical battery or trespass. If a surgeon operates on the wrong patient, he has operated without consent.<sup>17</sup> If the patient specifically prohibits the physician from removing any bone, and he does remove bone which in his judgment should be removed, he operates with

<sup>14</sup> *Franklyn v. Peabody*, 249 Mich. 363, 228 N. W. 68 (1930).

<sup>15</sup> *Hobbs v. Kizur*, 150 C. C. A. 13, 236 F. 681 (C. C. A., N. M., 1916);  
*Baxter v. Snow*, 78 Utah 217, 2 P. 2d 257 (1931).

<sup>16</sup> *Edwards v. Roberts*, 12 Ga. App. 140, 76 S. E. 1054 (1913).  
*Mokart v. Ziemer*, 67 Calif. App. 363, 227 P. 683 (1924) (removed the right testicle during a hernia repair and held liable for malpractice).

<sup>17</sup> 41 Am. Jur. 221;  
*Samuelson v. Taylor*, 160 Wash. 369, 295 P. 113 (1931).

<sup>18</sup> *Rotater v. Strain*, 39 Okla. 572, 137 P. 96 (1913).  
Against the express instructions of the patient, the surgeon removed bone from a diseased toe.

no consent.<sup>18</sup> A most horrifying situation that confronts a surgeon is the disclosure on a postoperative roentgenogram of an instrument or gauze sponge remaining in the abdomen. If he should operate a second time to rectify this error and to retrieve the foreign body, without first advising the patient of the situation and obtaining the patient's consent, the surgeon commits a trespass.<sup>19</sup>

The so-called strict jurisdictions have adopted the philosophy that no rule or principle of law extends to the physician free license respecting surgical operations. It is said that these jurisdictions restrict surgical endeavors to those to which the patient has specifically consented. From the medical viewpoint it is difficult to imagine how the cases could have been decided any other way. The courts in most of these instances have rendered decisions consistent with good medical judgment. It might be presumed that the patient expected treatment consistent with good medical practice.

The classic example used to illustrate a decision of the jurisdiction of strict interpretation is *Mohr v. Williams*.<sup>20</sup> The patient entered the hospital for an operation on her right ear, but while she was under general anesthesia the surgeon discovered that the left ear was involved to a greater degree. After consultation with the family physician, who was present in the operating room, the surgeon decided to operate on the left ear. The court found that the surgeon exceeded his consent. It is evident from the few facts presented that an adequate preoperative survey had not been done. A complete examination of both ears was the least to be expected before the patient was anesthetized and operated upon. The decision therefore does limit the consent, but it may have been the means to a just legal end.

The general rule that a surgeon operates at his peril without first obtaining the consent of the patient<sup>21</sup> or of someone lawfully authorized to consent for him, is qualified in most courts in cases of emergencies or of unanticipated conditions involving preserva-

<sup>19</sup> *Gist v. French*, 288 P. 2d 1003 (Calif., 1955). And see *Delahunt v. Fenton*, 244 Mich. 226, 221 N. W. 168 (1928).

Held that the surgeon had implied consent to operate upon the patient to extract a bougie which had become lodged in the patient's bladder.

<sup>20</sup> *Mohr v. Williams*, 95 Minn. 263, 104 N. W. 12, 1 L. R. A. (N. S.) 439, 111 Am. St. Rep. 462, 5 Ann. Cas. 303 (1905).

"If a patient consents to submit to a particular operation, he thereby enters into a contract authorizing his physician to operate to the extent of the consent given, but no further."

<sup>21</sup> 41 Am. Jur. 222.

tion of life or health of the patient, when it is impractical first to obtain consent to the operation or to the treatment which the surgeon deems necessary.<sup>22</sup> Some courts have held that consent is implied, or that the existence of an emergency may justify operating without consent. Other courts have held that the consent is not implied, but that the surgeon is reasonably privileged because he is reasonably entitled to assume that the patient would consent. In fact, the surgeon in an emergency is privileged to operate although the patient objects. It is well settled that in case of emergency a surgeon may lawfully perform, and it is his duty to perform, with or without the consent of the patient,<sup>23</sup> such operation as good surgical practice demands. In doing so, the surgeon is not liable for honest error in judgment.

Minors lack capacity to grant consent to surgical operations. Authorizations for minors should be reduced to writing, and signed by the parents or the guardian of the minor.<sup>24</sup> There have been instances where a minor of understanding years has been

<sup>22</sup> *Wheeler v. Barker*, 92 Calif. App. 2d 776, 208 P. 2d 68 (1949). And see *Barnett v. Bachrach*, 34 A. 2d 626 (D. C. Mun. App., 1943).

"To accept this view (unauthorized operation) we would have to deny that it was an emergency and declare a rule which would tend to make every surgeon litigation-conscious instead of duty-conscious, as he stands, scalpel in hand, over his unconscious patient. We hold the law to be that in case of emergency a surgeon may lawfully perform, and it is his duty to perform, such operation as good surgery demands even when it means extending the operation further than was originally contemplated." And see

*Luka v. Lowrie*, 171 Mich. 122, 136 N. W. 1106, 41 L. R. A. (N. S.) 290 (1912);

*Jackovach v. Yocom*, 212 Iowa 91, 237 N. W. 444, 76 A. L. R. 551 (1931).

"While the courts are not entirely in harmony upon the question of consent to an operation, we think the better reasoning supports the proposition that, if a surgeon is confronted with an emergency which endangers the life or health of the patient, it is his duty to do that which the occasion demands within the usual and customary practice among physicians and surgeons in the same or similar localities without the consent of the patient.

"Here, the seriousness of the condition of the boy whose elbow had been crushed by an accident which does not seem to have been fully disclosed until after he was placed under an anesthetic, along with the inability to reach either parent is regarded as justifying the operation as an emergency which called for immediate action."

<sup>23</sup> "... a surgeon may lawfully perform, and it is his duty to perform, such operation as good surgery demands, in case of emergency, without the consent of the patient."

*Luka v. Lowrie*, 171 Mich. 122, 136 N. W. 1106 (1912).

<sup>24</sup> *Wells v. McGehee*, 39 S. 2d 196 (La., 1949);

*Barfield v. S. Highland Infirmary*, 191 Ala. 553, 68 S. 30 (1915).

See also, *Lacey v. Laird*, 166 Ohio St. 12 (1956).



held to possess capacity to consent to an operation.<sup>25</sup> But the better rule is: In the absence of emergency, the surgeon operates on a minor at his peril without the parent's or guardian's consent. When an emergency is present, and the parent or guardian is unavailable, the surgeon's duty is to do that which the occasion demands in the best interests of the patient.

In summary, the surgeon operates at his own peril without first obtaining consent of the patient or of some one legally authorized to consent for him. In an emergency of unanticipated situation this rule is qualified and the surgeon may operate without consent. Caution, however, must not be abandoned. The rule laid down in *Mohr v. Williams*, that no rule or principle of law extends to the physician free license respecting surgical operations, still remains a much quoted principle of law. The physician should be always mindful that a consent is a privilege extended to him in good faith, through which he can violate one of the basic rights created in the common law. Any intentional deceit, fraud, or unworthy motive perpetrated under the protective cloak of this privilege can be the basis of action in battery. Those physicians who recognize and respect this privilege, and exercise it in good faith with reasonable skill and care, will be insulated from unjust liability.

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<sup>25</sup> *Bakker v. Welsh*, 144 Mich. 632, 108 N. W. 94, 7 L. R. A. (N. S.) 612 (1906).

Held that a father could not complain for an operation on his 17 year old son for a tumor, when the operation was not of a very dangerous character and there was nothing to indicate to the doctors, that the father did not approve of his son's going with his aunt and adult sisters to consult one of the doctors and following his advice.