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MALPRACTICE ACTIONS against professional medical practitioners are ordinarily thought of as being founded on a negligent act that results in injury to the patient. A number of cases, however, deal with another type of tortious conduct—the intentional infliction of harmful bodily contact on the person of the plaintiff. The tort is a battery, and the typical situation in which it arises is where an operation or treatment is performed on a patient who has not consented to it. This area of malpractice law takes its outlines from four early cases—*Mohr v. Williams,*[1] *Pratt v. Davis,*[2] *Rolater v. Strain,*[3] and *Schloendorff v. Society of New York Hospital.*[4] In *Mohr,* the physician obtained his patient's consent to an operation on her right ear, then performed an operation on her left ear. In *Pratt,* the patient consented to an operation on her womb. The operation went far beyond her expectations and her ovaries and uterus were entirely removed. In *Rolater,* a bone was removed from the patient's foot, although she had extracted a promise from the surgeon that he would not do this. In *Schloendorff,* an operation was performed on the patient while she was under anesthesia for diagnosis. In all four cases the defendants were held liable. Professor McCoid analyzed these four cases in an exhaustive and authoritative article in the *Minnesota Law Review*[5] which has become the point of departure for courts and subsequent writers. His synthesis of the four cases concluded that

> . . . [e]very 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.[6]

Classification of this tort as a battery has created a number of problems. Battery law developed certain doctrines long before modern medical practice took shape, and the context in which the law of battery evolved was the violent infliction of personal injury or indignity on another with an intent to do harm. These

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* Assistant Professor of Law, Emory University School of Law.

1 95 Minn. 261, 104 N. W. 12, 1 L. R. A. (n. s.) 439 (1905).

2 224 Ill. 300, 79 N. E. 562, 7 L. R. A. (n. s.) 609 (1906).

3 39 Okla. 572, 137 Pac. 96, 50 L. R. A. (n. s.) 880 (1913).

4 211 N. Y. 125, 105 N. E. 92 (1914).

5 McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 Minn. L. Rev. 381 (1957).

6 *Id.,* at 392.

doctrines have not proved useful in many situations involving the medical assault and battery, which is described by courts which find the classification bothersome as "technical" [7] assault and battery. The purpose of this paper is not so much to explore when and under what circumstances a battery takes place but to deal with the problems which the classification itself creates. These include questions of the applicability of special malpractice statutes of limitation, whether an action can be maintained under the Federal Tort Claims Act, coverage under malpractice insurance policies, causation and damages, and the requirement of expert medical testimony to provide a standard against which the conduct of the defendant may be measured.

Statutes of Limitation

Malpractice actions[8] in many states are subject to specific statutes of limitations,[9] some of which are shorter than the statute applicable to ordinary personal injury actions.[10] Frequently a tardy claimant will attempt to sue a physician on grounds subject to a more generous limitation. The attempts usually meet with failure. The general rule is that the applicability of the limitation is determined not by the form of the action, but by its object. The improper performance by a physician of his duties, whereby a patient is injured, is malpractice, and any action for damages is subject to the malpractice statute of limitations.[11] Thus attempts to avoid the statute by suing on a promise to cure,[12] false representations,[13] or a special wrong-

[7] See, *e.g.*, Lane v. United States, 225 F. Supp. 850 (D. C. Va. 1964).

[8] There is some diversity in the holdings as to which defendants are covered by such statutes. Compare Richardson v. Doe, 176 Ohio St. 370, 199 N. E. 2d 878 (1964), which held that actions against nurses were not encompassed by the malpractice limitations, with Monahan v. Devinny, 229 N. Y. S. 60, 223 App. Div. 547 (1954), following the more generally accepted view that suits against nurses are within the statute.

[9] Ala. Code Ann. tit. 7, § 25(1) (Supp. 1955); Ark. Stat. Ann. § 37-205 (1947); Colo. Rev. Stat. Ann. c. 87, § 1-6 (1953); Conn. Rev. Gen. Stat. § 52-584 (1958); Ind. Stat. Ann. § 2-627 (Burns Replacement 1946); Ky. Rev. Stat. Ann. § 413.140 (Baldwin 1955); Me. Rev. Stat. Ann. c. 112, § 93 (1954); Mass. Laws Ann. c. 260 § 4 (Michie Supp. 1963); Mich. Comp. Laws § 609.13 (1948); Minn. Stat. Ann. § 77.9193 (Mason 1927); Mo. Laws 1945, p. 644; Neb. Rev. Stat. Ann. § 25-208 (1943); N. H. Rev. Stat. Ann. § 508.4 (1955); N. Y. Civil Pr. Law & Rules § 214; N. D. Code Ann. § 28-01-18 (1960); Ohio Rev. Code Ann. § 2305.11 (Baldwin 1964); SDC 1960 Supp. 33.0232.

[10] Me. Rev. Stat. Ann. c. 112, § 93 (1954); Mich. Comp. Laws § 609.13 (1948); N. Y. Civil Pr. Law & Rules § 214; SDC 1960 Supp. 33.0232.

[11] Barnhoff v. Aldridge, 327 Mo. 767, 38 S. W. 2d 1029, 74 A. L. R. 1252 (1931).

[12] Baysinger v. Hanser, 355 Mo. 1042, 199 S. W. 2d 644 (1947).

[13] See, *e.g.*, Stacey v. Pantano, 177 Neb. 694, 131 N. W. 2d 163 (1964); Compare Camposano v. Claiborn, 2 Conn. Cir. 135, 196 A. 2d 129 (1963), where an assurance that an operation would leave only hairline scars came under the 3-year limitation for oral contracts rather than under the shorter malpractice statute.

ful death action,[14] are usually unsuccessful. Some states have the same limitation for assault and battery as for malpractice; [15] others have a longer statute of limitation for assault and battery than for malpractice. It may be predicted that unless the assault takes place outside the context of the physician-patient relationship, the malpractice statute will control. Apparently the same result occurs in those states which have a shorter statute for assault and battery than for malpractice. Colorado provides one year for assault and battery[16] and two years for malpractice.[17] Unauthorized operations there have been held to be controlled by the special malpractice statute. The Colorado court in *Maercklein v. Smith*[18] held:

> The majority rule is that such an action is essentially one involving negligence and that the statute of limitation respecting negligence cases is properly applicable regardless of the form of the action by which liability is sought to be enforced.[19]

While the legislative intent behind specific malpractice limitation statutes is not entirely clear,[20] it is clear that they will be held applicable even though the tort technically constitutes an assault and battery.

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[14] Barnhoff v. Aldridge, *supra* n. 11.

[15] *E.g.*, Ohio Rev. Code § 2305.11 (1953).

[16] Colo. Rev. Stat. Ann. § 87-1-2 (1963).

[17] Colo. Rev. Stat. Ann. § 87-1-6 (1963).

[18] 129 Colo. 72, 77, 266 P. 2d 1095, 1097 (1954). And see Francis v. Brooks, 24 Ohio App. 136, 156 N. E. 609 (1926). After the defendant, a dentist, had removed plaintiff's tooth by cutting away a portion of her jawbone, the jaw was broken. Plaintiff originally alleged "malpractice," and later amended to charge that she had objected to the removal of that particular tooth on the advice of her personal dentist and the removal had taken place over her protests. The statute of limitations for assault and battery was one year; the malpractice limitation then was longer. The dentist argued that the amendment was barred because the year prescribed in the assault and battery limitation had run. The court held that the assault and battery amendment was not a separate cause of action, but an incident of the malpractice, and did not change the basic malpractice character of the action.

[19] *Id.*, at 76. Dr. Roger Johnson, in Medical Malpractice—Doctrines of Res Ipsa Loquitur and Informed Consent, 37 Colo. L. Rev. 182 (1965), approves the result of the Smith case in that:

> "The obtaining of consent, be it 'informed' or 'uninformed,' constitutes and is a significant part of the over-all physician-patient relationship. If the treatment recommended to be performed and the patient's understanding of what is to be done do not coincide, an act of negligence may be the result—*i.e.*, the failure in the first instance, to inform of known or suspected inherent medical or surgical risks."

[20] It has been suggested that the statutes represented legislative reaction to judicial doctrines tolling the statute of limitations. Comment, Handling the Unique Problems of Medical Malpractice Actions, 10 S. Dak. L. Rev. 137 (1965).

Actions Under the Federal Torts Claims Act

Classification of a medical tort as an assault or battery has important consequences in actions under the Federal Torts Claims Act[21] which arises out of treatment in Veterans Administration Hospitals. In *Moos v. United States*,[22] the plaintiff had consented to an operation on his left leg and hip. After regaining consciousness, he found that the operation had been mistakenly performed on his right leg and hip. The court concluded that this constituted an assault and battery under Minnesota law, citing *Mohr v. Williams*,[23] and further noted that such classification was not peculiar to that jurisdiction but was the general rule. This brought the action within the exception of Section 2680(h) of the Federal Torts Claims Act,[24] which exempts the government from "any claim arising out of assault and battery." The court's reasoning was that since there appeared no legislative intent to confine this section to traditional assaults, classification of the act as an assault and battery meant exclusion.

Subsequent litigation on this point has generally dealt with attempts to show that although the injury was directly caused by an assault and battery, actionable negligence on the part of the government employees exposed the patient to the battery. In *Moos*, the plaintiff was unable to found his action on the negligence of the hospital personnel in transferring the site of the operation, since the injury "arose out of" [25] the assault and battery. However, in *Panella v. United States*[26] a hospital inmate recovered damages when stabbed by another inmate on the theory that the hospital negligently failed to supervise. In a later case a patient failed to recover damages when the assault and battery was committed by professional personnel.[27] The rule seems to be that if the tort is classified as an assault or battery, negligence leading up to the final tortious act is excluded under the Act when committed by government employees, because Congress intended to bar such suits under whatever legal theory they may be brought.[28] This approach has been carried to what one must hope are its limits in *Pendarvis v. United States*,[29] where the plaintiff was seized and beaten by

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[21] 28 U. S. C. § 1346(b) (1940).

[22] 118 F. Supp. 275 (D. Minn. 1954), aff'd, 225 F. 2d 705 (8th Cir. 1955).

[23] *Supra* n. 1.

[24] 28 U. S. C. § 2680(h) (1952). This section further excludes "false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, misrepresentation, deceit, or interference with contract rights."

[25] *Supra* n. 22.

[26] 216 F. 2d 622 (S. D. N. Y. 1954).

[27] Rufino v. United States, 126 F. Supp. 132 (S. D. N. Y. 1954).

[28] See Klein v. United States, 268 F. 2d 63 (2d Cir. 1959).

[29] 241 F. Supp. 8 (D. C. So. Car. 1965).

a band of soldiers while he stood in the front yard of his home. Later he was taken by the soldiers to a field hospital. There he was treated in an allegedly negligent manner which caused additional injuries. The action by the soldiers constituted a battery, and thus was excluded. But the court held that recovery for the subsequent negligent medical treatment also was barred. The medical treatment that was given to the plaintiff was a direct result of the assault and thus was excluded. The court felt that

> It would be illogical to hold that the government could not be held liable if plaintiff had been instantly killed while being assaulted, and that the government could be liable for allegedly negligent medical treatment of non-fatal wounds resulting from the assault.[30]

If this case is followed, it will mean that not only is malpractice by professional personnel which is classified as assault and battery excluded under the Act, but it will mean that it is excluded even though it is mere professional negligence if the reason the patient needs medical attention in the first place is because he was victimized by an assault and battery at the hands of a government employee. Although this might prove to be a boon to experimental medicine, the case is wrong, and it should not be followed. Where the initial assault and battery is committed by persons having no connection with the medical treatment of the injury, and the medical negligence is subsequent thereto, the medical negligence should be actionable without reference to the reasons why treatment was needed. If the courts feel compelled to follow *Moos*, it is sufficiently limited by holding that negligence involved in the medical treatment, by medical personnel, cannot be isolated and sued upon but is merged with the medical battery that finally results.

Recently *Moos* has come under direct attack in a case in another Circuit Court. In *Lane v. United States*[31] the only factual distinction from the *Moos* case, other than the plaintiff's sex, was that the surgeon operated on the wrong knee rather than on the wrong hip. In *Lane* the court said *Moos* was wrong. It agreed that the general rule was that such an unauthorized operation was regarded as an assault and battery, but felt that Congress never intended the "assault and battery" language to cover "technical" [32] assaults which were clearly unintended. The surgeon did not commit an intentional wrongful act, but one which arose out of his negligence.

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[30] *Id.* at 10.

[31] *Supra* n. 7.

[32] *Id.*, at 853.

Coverage Under Malpractice Insurance Policies

Insurance coverage in malpractice cases can be troublesome when the tort is classified as assault and battery. The problems are, first, that the public policy is against permitting one to insure against liability for his illegal and wilful acts on the theory that insurance would encourage such activities; [33] and second, whether assault and battery is included within the general coverage clause[34] and not excluded by the exceptions.

The public policy argument against such insurance, which is itself subject to doubt as to its continued validity,[35] should not and has not been applied to prohibit malpractice insurance against assault and battery claims.[36]

Litigation in this area has to do with policy coverage. There are suprisingly few cases. There are perhaps two explanations for this. The first has to do with successfully writing and selling such policies. Doctors are extremely concerned with their malpractice coverage.[37] Medical publications are filled with articles dealing with malpractice insurance coverage,[38] and some firms specialize as Medical Insurance Consultants.[39] With such chains of communication open, it would be unwise for an insurance company to litigate coverage on the basis that technically assault and battery might not be covered. The other reason is that the courts would not be sympathetic to such arguments.

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[33] See, *e.g.*, Northwest Amusement Co. v. Aetna Casualty & Surety Co., 165 Ore. 284, 107 P. 2d 110, 132 A. L. R. 118 (1940).

[34] Hirsch, Insuring Against Medical Professional Liability, 12 Vand. L. Rev. 667, at 669 (1959):

> "Most companies use the form of the Physicians', Surgeons', and Dentists' Professional Liability Policy adopted by the National Bureau of Casualty Underwriters. The coverage provisions state that the company agrees:
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> "To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of injury arising out of malpractice, error or mistake in rendering or failing to render professional services in the practice of the insured's profession. . . (.)"

[35] See, *e.g.*, Wolff v. General Casualty Company of America, 68 N. M. 292, 361 P. 2d 330 (1961), holding that a policy insuring against liability for personal injury claims without expressly limiting coverage to accidents or excepting law violations covered liability for injuries resulting from assault and battery.

[36] It has been suggested that public policy should prohibit a clause in a malpractice insurance policy which would ". . . release an insurer from claims resulting from unlawful acts, such as assault and battery in operating without permission." Franklin, What Should Be in a Malpractice Insurance Policy, 14 Clev.-Mar. L. Rev. 478, at 482 (1965).

[37] See generally, Schroeder, Insurance Protection and Damage Awards in Medical Malpractice, 25 Ohio St. L. J. 323 (1964).

[38] The Journal of Medical Economics carried some thirteen articles on insurance in 1965.

[39] Firms regularly advertise in medical periodicals as "Medical Insurance Specialists."

Typical of the judicial attitude towards insurance coverage is *Shehee v. Aetna Casualty and Surety Co.*[40] The patient had been subjected to an esophagoscopy, during the course of which her esophagus was punctured. Complications resulted. The patient successfully contended that the operation was undertaken without her consent. The insurance company then maintained that its policy did not cover any liability of the physician for performing an operation without the consent of the patient. The basic coverage clause provided general coverage against damages "on account of any malpractice, error, or mistake." However, the policy further provided that "Assault and battery shall be deemed an accident within the meaning of this Policy unless committed by or at the direction of the insured." The court noted that the insured by paying premiums would expect to be covered in this situation. Also, the insurer would share in the idea that the intent of the clause was to exclude "assault and battery" committed by wilful violence. The court held

> [A] reasonable interpretation of the term "assault and battery" as used in the policy provision quoted, is that it means a willful 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.[41]

The thrust of this holding is weakened by the court's going on to draw a distinction between "assault and battery" and malpractice. Noting that the fundamental distinction between assault and battery and negligence constituting malpractice is that the former is intentional and the latter unintentional, the court said:

> [F]ailure 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 was covered by the policies.[42]

The conclusion that may be drawn from this is that operations without the consent of patients will be found covered by standard malpractice insurance policies, as both the insured and the insuror expect them to be. In *Shehee,* the court felt that it was necessary to disagree with the general classification of such torts as "assault and battery." However, the point is that it did whatever it felt necessary to conclude that coverage existed.

More difficult cases are presented where the tort not only is classified as assault and battery, but also falls within local definitions of "criminal" acts. Many malpractice policies ex-

[40] 122 F. Supp. 1 (W. D. La. 1954).

[41] *Id.,* p. 6.

[42] *Ibid.*

clude liability in these situations.[43] In *Thoresen v. Roth*,[44] the plaintiff alleged that he was examined without authorization by a psychiatrist, given sedatives without his consent, and while unconscious taken to a psychopathic hospital and held for several days against his will. His action was for assault, false imprisonment, violation of civil rights, and violation of the Illinois Mental Health Code. The court held that this was covered by the malpractice policy distinguishing between the "legal theories of recovery" [45] and the "operative facts of the claim." [46] The operative facts of the claim were that the nurses administered the sedative and removed him to the psychopathic hospital. This was ". . . rendering or failing to render . . . medical . . . or nursing treatment," and was thus malpractice within the policy definition. Other courts have held squarely that "Malpractice includes the performance of criminal acts." [47] And more recently,[48] when the insurance company failed to defend the insured in an action for assault for placing the patient in a sanitarium for the mentally ill on the basis that this was "a criminal assault," the court in holding for the insured asked:

> Can the defendant offer plaintiff a policy to protect him from damages for malpractice (which embraces an assault) in one breath, and then in the other breath turn around and exempt assault? If that be the case what have they given to the insured? [49]

The "criminal acts" exclusion does serve some purpose. It is thought that such language would cover abortions, etc., but insurance coverage under the standard clause might prove questionable in a case such as one where a Georgia doctor, in a fit of pique because his patient rebelled at taking some medicine he had prescribed, ordered her strapped down on the operating table. He told her that the best way to examine her healing appendectomy scar was to go through her vagina and uterus. While she screamed and pleaded, he thrust a surgical instrument into her womb and twirled it violently, dismembering and killing an unborn child. He then left the patient to get off the table,

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[43] Hirsch, *supra* n. 34, at p. 671.

[44] 351 F. 2d 573 (7th Cir. 1965).

[45] *Id.*, p. 567.

[46] *Ibid.*

[47] Bakewell v. Kahle, 232 P. 2d 127 (Mont. 1951) (chiropractor made an "adjustment" over the protests of the patient); Cramer v. Price, 84 Ohio App. 255, 82 N. E. 2d 874 (1948) (holding that under Ohio law malpractice covers even unlawful, wilful acts); Physicians' and Dentists' Business Bureau v. Dray, 8 Wash. 2d 38, 111 P. 2d 568 (1941) (unauthorized removal of uterus, an illegal act, was "malpractice").

[48] Sommer v. New Amsterdam Casualty Company, 171 F. Supp. 84 (E. D. Mo. 1959).

[49] *Id.*, at 87.

struggle into her clothes, and get home the best way she could. All the while she was bleeding copiously.[50] Would this be covered by a standard policy which insured against claims arising out of "malpractice," but excluded "assaults and batteries"? The probable holding would be that it does not. The courts now hold that "inadvertent" acts of physicians, which technically amount to assault and battery, are covered by the "malpractice" clause. The intent of the assault and battery exclusion clause is to exclude wilfully criminal acts. It would not be inconsistent then to rule that it is within the intent of the policy to exclude those acts of physicians which, although arising in some manner out of the physician-patient relationship, are designedly wicked.

Damages and Causation

It is not necessary to show actual physical injury to recover damages in assault and battery cases.[51] Some cases, such as that involving a patient who received a fellow patient's vasectomy rather than the hemorrhoid operation he expected,[52] create damage issues which are much better handled by the ingenuity of trial counsel than in the vacuum of reading appellate decisions. In other medical assault and battery cases, however, the treatment is undertaken in good faith by the physician, performed with the requisite professional skill, and the result is beneficial. If the treatment is unauthorized it has invaded the patient's right to be free from unwanted contact, and the invasion of this interest is compensable. The principal item of damages is "bodily harm." Pain or any impairment or alteration of the physical condition of the body constitute bodily harm.[53] Thus in *Church v.*

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[50] Keen v. Coleman, 67 Ga. App. 331, 20 S. E. 2d 175 (1942).

[51] Prosser, Law of Torts, § 9 (3d ed. 1964).

[52] Huggins v. Graves, 337 F. 2d 486 (6th Cir. 1964).

[53] Restatement, Torts § 15 (2d Ed. 1965). Special circumstances may increase damages in a given case. As to "consequential damages" see Corpman v. Boyer, 171 Ohio St. 233, 169 N. E. 2d 14 (1960) and the comments thereon in, Oleck, Cases on Damages, 50 (1962). In Rogers v. Lumbermens Mutual Casualty Company, 119 So. 2d 649 (La. App. 2d Cir. 1960), the surgeon extended his appendectomy operation and performed a hysterectomy. Apparently good surgery and medical ethics both dictated that the operation be extended, but the lack of an emergency made the extension tortious. Even though the results were beneficial, damages were awarded. The special circumstances that justified the award were the patient's background. After having one child, she remarried, and desperately wanted to have more children. She had been consulting doctors for six years in a fruitless quest to become capable of having children, and convincing testimony was elicited to the effect that she attached great importance to this and would never have consented to an operation that would remove her reproductive organs.

Adler,[54] where the physician extended the scope of his operation to remove the patient's diseased ovaries, to which the patient had consented, and performed an appendectomy to which she had not consented, the patient was allowed to recover over an argument that the appendectomy benefited rather than injured her. The Restatement of Torts drives home this principle by using the illustration of a patient who protests treatment stating that even if medical testimony shows the patient would have died without the operation and that the operation effected a complete cure, the physician would still be liable.[55] It seems reasonable that this would be tempered by the proposition that damages may be reduced where a diminution of future pain or illness by the performance of a necessary operation can be demonstrated.[56] The relative modesty of some awards in the operations which are extended beyond the area of consent[57] can perhaps be explained on the grounds that this was argued effectively to the jury.

The technical assault and battery cases in medical torts perhaps are different in some respects from the traditional handling of wilful assaults where the defendant intends to do harm. A general observation may be made that the causal connection between intentional torts and compensable damages is demanded with much less vigor by the courts than that causal connection which must be present between a negligent act and the injury.[58] In other words, the ambit of liability is greater for intentional

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[54] 350 Ill. App. 471, 113 N. E. 2d 327 (1953). Compare Wilson v. Lehman, 379 S. W. 2d 478 (Ky. App. 1964), where the court said "it was interesting to note" that although the patient alleged injury because of the treatment, her testimony showed much improvement in her condition. This perhaps had a bearing on the court's finding against the patient on another point.

[55] Restatement (2d), Torts § 13(c) (1965).

[56] Restatement, Torts § 920 (1934).

[57] See, *e.g.*, Rogers v. Lumbermens Mut. Cas. Co., *supra* n. 53 at 652 ($3,500.00 in damages was awarded for a complete hysterectomy). The case attracted some attention also for its holding a consent form, which was apparently fairly standard at the time, as "having no possible effect upon the legal issue of consent . . .", it being "so ambiguous as to be almost completely worthless." Each such decision produces a redrafting of consent form, and now a number of them are used for the same operation. The signature of not only the patient but his family are customarily procured. It appears that one difficulty is that surgeons do not like to specify the particular treatment, doubtless because of the notion that without specification they can extend or vary the operation as medical exigencies dictate. Ruth R. Budd, Consent Forms and Procedures in Atlanta Hospitals (1964) (on file at offices of the Journal of Public Law, Emory Law School, Atlanta, Ga.).

[58] A typical statement illustrating this principle was made by the court in Kopka v. Bell Telephone Co., of Pennsylvania, 371 Pa. 444, 445, 91 A. 2d 232, 234 (1952), where the court said, "The authorities are clear to the effect that where the complaint is for trespass . . . the trespasser becomes liable not only for personal injuries resulting directly and proximately from the trespass but also for those which are indirect and consequential."

torts. This is not always true where the assault and battery was committed by a surgeon acting in good faith and without provable negligence. The causal connection between the battery, the unauthorized treatment, and the item for which compensation is sought, must be proved, and a mere coincidence in time between tort and injury will not suffice. Thus in *Butler v. Molinski*,[59] the plaintiff was relegated to nominal damages when she failed to establish that the deformity of her hand was attributable to the unauthorized treatment, rather than to the injury which itself initially necessitated some treatment.

A more elusive causation—damages problem is created in those cases where the tort lies in the failure of the physician adequately to inform the patient of those risks attendant on a particular treatment. These are the "informed consent" cases. Typically they involve treatment which, though conducted skillfully, can result in injury from dangers inherent in the procedure. Such cases generally fall into two categories. One is illustrated by *Bang v. Charles T. Miller Hospital*,[60] where the patient was not informed that part of the procedure of a transurethral prostatic resection would be the tying off of his sperm ducts. The court said that he should have been informed that the surgery would result in his sterilization and that failure to tie the ducts off could result in a serious infection with dire consequences. This would have given him the opportunity to decide intelligently whether to undergo the operation. This is a case where the treatment did not miscarry, and the undisclosed consequence was not a "risk" but a certainty.

The other type of informed consent case deals with the unexpected bad result; the unexplained risk that comes to fruition. In *Natanson v. Kline*[61] cobalt radiation treatment, administered without negligence, produced serious injuries. The dangers of this treatment are great, and such results can sometimes be expected. The court in commenting on the causal connection between the failure to warn and the injury, set out the necessary causal connection in both types of informed consent cases. If the patient would have taken the cobalt radiation treatment even though the physician warned her it involved a great risk of bodily injury, the failure to warn could not be considered the proximate cause of the injury. Physicians have suggested that in many cases the patient would consent to go ahead with the operation even if all the unfortunate possibilities were explained to him.[62] If a physician can successfully convince the jury of this, then according to *Natanson* there would be no

[59] 198 Tenn. 124, 277 S. W. 2d 448 (1955).

[60] 251 Minn. 427, 88 N. W. 2d 186 (1958).

[61] 187 Kan. 186, 354 P. 2d 670 (1960).

[62] See generally, Oppenheim, Informed Consent to Medical Treatment, 11 Clev.-Mar. L. Rev. 249 (1962).

causation and thus no recovery. This has probably been the case in some instances, such as one where the plaintiff found herself in the position of arguing that if she had been informed that the risk of contracting viral hepatitis from a whole blood transfusion was less than 1% and that the fatality rate from the disease was one-half of that, she would have refused the badly needed transfusion.[63]

It is arguable that this causation requirement does not conform to traditional battery law, at least in the cases centered on the miscarriage of careful treatment. It is also questionable whether it poses much of a problem for plaintiffs. In *Natanson,* the jury was permitted to infer from the evidence as a whole that the plaintiff, if properly warned of the risks, would have declined to undergo the treatment. Plaintiff's direct testimony was not required.[64] In cases where the question of whether he would have declined the operation if informed is put to the plaintiff, who has recently acquired first-hand knowledge of what he is risking, his denial that he would have undergone the operation will have a ring of sincerity that will convince any fact-finder. If the battery classification is to be carried into this area with all its implication, and if a battery includes any unconsented-to contact that produces bodily harm, the battery commences as soon as the operation begins, and it does not "ripen" when the operation miscarries. The operation itself from its inception is the battery. This being the case, the miscarriage of the operation is simply a compensable consequence of the battery. This approach would focus the attention of the courts on the real problem (i.e. whether an intelligent consent could have been given without disclosure of certain risks) rather than on the unproductive and predetermined question of whether the patient would have gone through with the treatment with knowledge of its hazards. Two situations might arise which would test this analysis. In the first, the physician fully and completely informs the patient of risk A, and the patient consents to the operation. The physician fails, however, to warn of risk B. During the operation risk A occurs, causing injury. The patient later peruses

[63] Fischer v. Wilmington General Hospital, 51 Del. 554, 149 A. 2d 749 (Del. Super. 1959). The court here found no showing of proximate cause between the failure to warn and the contraction of the disease. See also Govin v. Hunter, 374 P. 2d 421 (Wyo. 1962); where the medical history of the patient suing because she was not informed that a number of incisions would be necessary to strip varicose veins from her legs seemed to make the court dubious as to whether she was really induced to take the operation. The court pointed out that she had had similar surgery on her other leg, that the veins were enlarged and quite painful, and that she had come to the defendant for the operation.

[64] Natanson v. Kline, 187 Kan. 186, 189, 354 P. 2d 670, 673 (1960). Compare Govin v. Hunter, *supra* n. 63, at 374 P. 2d 421, 423, where the court stated: "No doubt plaintiff's testimony would nevertheless have been sufficient to go to the jury if it had been coupled with substantial evidence to show that plaintiff was induced by the alleged statements to have the operation."

his medico-legal books and discovers that the physician should have warned of risk B. His consent to the operation was not "informed," the operation was a battery, and damages could include those injuries caused by risk A. In the second situation a physician could be sued for performing a careful and successful operation with no side effects or harmful results because he failed to warn the patient of some of the reasonable risks of the operation even when none of those risks became reality. In both situations a strict application of battery principles would result in liability, and in neither would this be a desirable result. The causation requirement would prevent the undesirable holding. This desirable inconsistency with battery law in the causation requirement stems from an appreciation by the courts that in many instances they are dealing with torts which in some areas are better handled by shading into negligence principles.

The Requirement of Expert Testimony

The question of whether expert medical testimony is required for a plaintiff's case for malpractice is one which has been subjected to much discussion by courts and writers. An exhaustive annotation concludes that the overwhelming weight of authority is that it is required.[65] The difficulty that this rule poses, in view of the attitude of the medical profession towards malpractice actions against its doctors,[66] is too well known to merit discussion. The assault and battery classification seems to hold out a possibility of providing another method[67] of circumventing the "conspiracy of silence." It has been said that "the chief utility (of an assault count) from the plaintiff's viewpoint is to negate the need of expert testimony to establish negligence," [68] and it has been termed a "wonder drug for plaintiffs." [69] In the battery action, the question of whether a given risk was discussed with the patient is a question of fact[70] and one which the jury can determine on the basis of the conflicting oaths of the patient and the physician. Inasmuch as a battery case theoretically dispenses with the question of whether the

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[65] Annot., 141 A. L. R. 2d 6 (1959).

[66] See generally Markus, Conspiracy of Silence, 14 Clev.-Mar. L. Rev. 520 (1965).

[67] Other judicially developed doctrines that are undoubtedly due in part to the difficulty of obtaining medical testimony include *res ipsa loquitur* and the expanding rules of competence of medical witnesses; *i.e.*, the relaxation of the requirement that testimony must be elicited from a physician familiar with local standards of professional competence.

[68] Louisell & Williams, Trial of Medical Malpractice Cases, 224 (1960); McCoid, *op. cit. supra* n. 5 at 384.

[69] Karchmer, Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug," 31 Mo. L. Rev. 29 (1965).

[70] See Woods v. Brumlop, 71 N. M. 221, 377 P. 2d 520 (1962).

treatment was skillfully administered, medical testimony to establish the standard of professional care in the community is not needed. This question has been treated by many writers, and the cases bearing on it have been collected and exhaustively analyzed in a number of articles.[71] There is no need to plow this ground again. However, it is submitted that a blanket statement that assault and battery actions need no expert medical testimony is too broad and needs many qualifications. It goes too far because a number of courts appear to treat the "informed consent" cases as "malpractice" cases and avoid categorizing them as assault and battery situations.[72] When this is done, expert testimony enters the picture. The statement is also misleading because of the "informed consent" rule itself, and also because of the exceptions to the rule.

The "informed consent" rule, as formulated by McCoid and accepted by many courts, is that the physician has a duty to make a reasonable disclosure of the nature of the infirmity, the nature of the operation, and some of the more probable consequences and difficulties inherent in the proposed operation.[73] These consequences and difficulties have been termed the "recognized risks" [74] of the treatment. The difficulty lies not in the factual determination as to what was disclosed to the patient; it lies in the establishing of the "recognized risks." This can

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[71] See, *e.g.*, Annot., 79 A. L. R. 2d 1028 (1961); Annot., 99 A. L. R. 2d 599 (1965); 1 Averbach & Belli, Tort and Medical Yearbook 455 (1961); Bellamy, Malpractice Risks Confronting the Psychiatrist: Nationwide Fifteen-Year Study of Appellate Court Cases 1946-1961, 118 Am. J. Psychiatry 769 (1962); Franklin, Medical Mass Screening Programs: A Legal Appraisal, 47 Cornell L. Q. 205, 218 (1962); Hendrix, Informed Consent—New Area of Malpractice Liability, June, 1960 Medicolegal Digest 11; Johnson, Medical Malpractice Doctrines of Res Ipsa Loquitur and Informed Consent, 27 Colo. L. Rev. 182 (1965); McCleary, Torts in Missouri, 27 Mo. L. Rev. 81 (1962); Oppenheim, Informed Consent to Medical Treatment, 11 Clev.-Mar. L. Rev. 249 (1962); Note, Doctors Held to Have Duty to Disclose Risk Inherent in Proposed Treatment, 60 Colum. L. Rev. 1193 (1960); Note, Informed Consent—Reluctance of Doctors to Inform Patients Often Renders Them Liable in Malpractice for Lack of "Informed Consent," 11 Current Med. for Attorneys 24 (1964); Note, Informed Consent—New Theory of Liability—Doctor's Nightmare in Malpractice, 8 Current Med. for Attorneys 35 (1961); Note, Physicians and Surgeons—Physician's Duty to Warn of Possible Adverse Results of Proposed Treatment Depends Upon General Practice Followed by Medical Profession in the Community, 75 Harv. L. Rev. 1445 (1962); Note, Malpractice—Doctors Under Duty to Disclose Risk Inherent in Proposed Treatment, 26-27 NACCA L. J. 134 (1960-1961); Note, Malpractice—Physician Has a Duty to Inform Patient of Risk Inherent in Proposed Treatment, 109 U. Pa. L. Rev. 768 (1961); Comment, The Law of Medical Malpractice in Missouri, W. U. L. Q. 402, 414-15 (1962); Karchmer, Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug," 31 Mo. L. Rev. 29 (1965). An excellent student note on the subject appears in 4 Duquesne L. Rev. 450 (1966).

[72] See, *e.g.*, Miles v. Van Gelder, 1 Mich. App. 522, 137 N. W. 2d 292 (1965).

[73] McCoid, *op. cit. supra* n. 5 at 427.

[74] Woods v. Brumlop, *supra* n. 70.

be ascertained only by medical experience, and testimony is needed in all but clear-cut cases that the particular risk lay within the range of the "more probable consequences and difficulties inherent in the operation." Some courts, recognizing that this question ultimately depends on the medical profession, have said that whether certain possibilities should have been disclosed depends on an inquiry into what the local medical profession would do in such a case[75] and that the custom of the medical profession to warn must be established by expert medical testimony.[76] This approach clouds the issue. Even if the local profession does not inform of certain risks, this has only a derivative relevance on the question of whether the risk is so likely to occur that a patient should be informed of it. This approach has been discredited in other areas of tort law, and it is quite clear that an industry cannot by concurring in substandard practices set their own standard of care. The proper inquiry to put to the medical profession is what can happen, and how likely is it to happen? The essential question is the quantity and quality of the risks not whether the profession customarily warns of such possibilities. But with this approach medical testimony often will be required, with all that the requirement portends. It would seem reasonable to permit a plaintiff in such cases to establish the risks attendant on a given treatment by reference to either medical testimony *or* to medical literature.[77] A statistical showing could suffice to show that a given bad result of an operation was sufficiently likely to come about to demand that the patient be warned.

One of the exceptions to the "informed consent" rule inevitably leads to expert testimony being put into the case. That exception is that full disclosure is not demanded where an explanation of every risk may result in alarming a patient who is already apprehensive and where such disclosure would tend to increase the risk itself by subjecting the patient to emotional upset.[78] Although this will ordinarily be dealt with as a matter of defense and the burden of coming within this exception after a prima facie case of no consent has been made rests on the defendant,[79] it would be wise for the plaintiff to counter with expert testimony of his own.

This is not to say that one cannot avoid the requirement of

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[75] Natanson v. Kline, *supra* n. 64, at 1106; Phifer v. Baker, 34 Wyo. 415, 244 Pac. 637 (1933).

[76] Govin v. Hunter, *supra* n. 63.

[77] Two states have enacted statutes permitting the use of medical treatises. Mass. Ann. Laws ch. 233, § 79 c (1956); Nev. Rev. Stat. § 51.040 (1960).

[78] Salgo v. Leland, 154 Cal. App. 2d 560, 317 P. 2d 170 (1957); Natanson v. Kline, *supra* n. 64; Hunt v. Bradshaw, 242 N. C. 517, 88 S. E. 2d 762 (1955).

[79] In Woods v. Brumlop, *supra* n. 70, defendant failed to introduce evidence of the emotional condition of the plaintiff, and thus failed to come within the exception.

expert testimony in a battery case. However, whether such testimony is required must depend upon the facts of each case. In clear-cut situations, such as where the operation extends to and injures another part of the body not under treatment,[80] or where the operation includes what has been expressly prohibited by the patient,[81] no expert testimony will be required to prove any part of the patient's case. In other cases, where the assault and battery are truly technical, expert testimony will be required. Two recent Michigan cases draw the line between these situations.

In *Miles v. Van Gelder*,[82] the plaintiff underwent a hemilaminectomy to correct what had been diagnosed as a slipped disk. After the operation the incision failed to heal properly, and spinal fluid drained from it for some time. The plaintiff's action was founded in part on the failure of the defendant to warn him that the operation could result in this condition. The court applied the general rule in malpractice situations, *i.e.*, that the conduct on the part of the defendants must be proved to fall below the standard of the medical practitioner in the locality. Thus expert testimony was demanded.

A few months later the same court decided the case of *Schulman v. Lerner*.[83] The plaintiff went to the defendant, an ophthalmologist, suffering from an apparent sty. The diagnosis was that the membomian glands were infected and would have to be drained. The plaintiff was prepared for treatment; a local anesthetic was administered; and instead of merely draining the glands, the defendant removed them along with a stray freckle. The action here was assault and battery, and the issue was whether plaintiff impliedly consented to the removal of the glands. He did not consent and recovered with no expert testimony required.

Conclusion

When compared with other illnesses of the law of medical malpractice, the technical assault and battery problem does not appear to be a major one. It is useful enough when the medical treatment is wholly without consent, when the operation extends to parts of the body not within the immediate area the treatment was scheduled for, and when the physician has deceived the patient. The problems arise when the case deals with partial consent and when the plaintiff's charge is that while he consented to the operation, he was not adequately informed of its risks. In most of these cases the treatment has miscarried, and

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[80] See, e.g., Johnson v. Van Werden, 255 Iowa 1285, 125 N. W. 2d 782 (1964).

[81] Rolater v. Strain, *supra* n. 3.

[82] *Supra* n. 72.

[83] 2 Mich. App. 705, 141 N. W. 2d 348 (1966).

the assault and battery classification shades into this area because of judicial pressure which recognizes the difficulty plaintiffs have in proving negligence. The effectiveness of this as a solution to the difficulties of making a case is diminished considerably in that in the majority of informed consent cases the plaintiff will need expert testimony at some stage of the trial. This is remedied not by an expansion of assault and battery law, but by more direct approaches such as admission of medical literature to establish professional misconduct, expanding the class of eligible medical witnesses both geographically and in terms of specialties, or best of all, obtaining the cooperation of the medical profession.

In other problem areas courts have shown considerable flexibility. Special malpractice statutes of limitations apply rather than assault and battery limitation statutes; causation is handled in a way more nearly similar to negligence doctrines than traditional assault and battery doctrines; malpractice insurance policies are construed to cover liability losses, as doctors reasonably expected they would; damage awards seem to take into consideration the fact that sometimes a benefit occurs to the plaintiff. The only area where judicial treatment has seemed unwise is in actions under the Federal Torts Claims Act. It is doubtful whether Congress ever thought of the technical medical assault and battery situations when they excluded batteries by government employees, and a one-case trend has developed to correct earlier holdings that such actions were barred. Both assault and battery actions and traditional negligence actions are losing their shape as courts develop a body of malpractice law with its own structure to deal with torts arising out of the doctor-patient relationship.