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Physicians and Surgeons - Unauthorized or Unnecessary Operation - Informed Consent [*Gary v. Grunnagle*, 223 A.2d 663 (Pa. 1966)]

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people rather than having a large economic loss sustained by one person.[14]

Wollerman espouses a minority view and extends the normal application of res ipsa loquitur by enlarging the standard of care owed to a business invitee. However, the decision did not advocate that the self-service store owner become an insurer. Instead, a plaintiff should be granted recourse to res ipsa loquitur only when a high standard of care is owed him, when the cause of his injury is foreseeable by the defendant, and when the defendant's superior knowledge enables him to best explain how the injury occurred. What this promotes is care commensurate with the risks involved.

DONALD A. INSUL

PHYSICIANS AND SURGEONS — UNAUTHORIZED OR UNNECESSARY OPERATION — INFORMED CONSENT

Gray v. Grunnagle, 223 A.2d 663 (Pa. 1966).

The plaintiff consulted an orthopedic surgeon for treatment of his atrophied left leg and two weeks later was admitted to the hospital where he signed a "Consent to Operation."[1] Subsequently, the plaintiff was referred to the defendant neurosurgeon, who competently performed an exploratory laminectomy,[2] as a result of which the plaintiff became paralyzed from the waist down. The plaintiff brought suit against the surgeon, asserting injuries and damages caused by negligent surgery and diagnosis, abandonment,[3] and failure to secure the necessary consent.[4]

The trial court ruled that the case could not go to the jury on the issue of negligence, and when the plaintiff withdrew his charge of abandonment, the case was submitted to the jury solely on the issue of consent. A verdict was returned for plaintiff, but the court sitting *en banc* reversed by granting judgment notwithstanding the

[14] Application of the "deep-pocket" theory can be found in UNIFORM COMMERCIAL CODE § 2-314. Under this section the drafters of the code have decided to hold the seller responsible for the goods he sells. He can be liable for defects of which he may not have been aware and even for which he may not have been responsible. By analogy, it is seen that the owner of the self-service store may not be the person responsible for the injury sustained by the plaintiff, yet he will be constrained to show what steps have been taken to prevent injuries from occurring on the premises. Under both the UCC and res ipsa loquitur there is an intent to protect customers, for in most circumstances they are less able to absorb the expense of an injury and have less opportunity to insure against it.

verdict. On appeal, the Pennsylvania Supreme Court held that the issue of consent was properly submitted to the jury and reinstated the jury's verdict.[5] It was decided that the defendant could not have assumed the consent form was intended for him because it was signed before he was referred to the plaintiff. Even apart from this deficiency, the consent would not have barred the action because it " 'was not given with a true understanding of the nature of the operation to be performed.' "[6] A vigorous dissent attacked the majority's decision for ignoring the parol evidence rule and predicted that increased medical malpractice litigation would result.[7]

Generally, a physician's liability in a medical malpractice action is predicated on negligence.[8] However, even where the physician is personally free from negligence in the actual treatment of or op-

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[1] A "Consent to Operation" is a generalized form used by most hospitals. It is an agreement in which the patient acknowledges that he is to be operated on and authorizes the physicians of the hospital to perform whatever operative procedures they deem necessary. See Hirsch, *Consent to Medical Treatment — With Forms*, 5 TRIAL LAW. GUIDE 51 (1961).

[2] This is a surgical operation in which the posterior arch of the vertebra is removed. The vertebrae are "bone blocks" of which the spine is comprised. SCHMIDT, ATTORNEY'S DICTIONARY OF MEDICINE 431 (1965).

[3] Abandonment is an actionable type of malpractice occurring when a physician unreasonably terminates the physician-patient relationship and injury directly results. For a general discussion of the subject, see 36 TUL. L. REV. 834 (1962).

[4] "Consent" is abstractly defined as a concurrence of wills or a voluntary yielding of the will to the proposition of another. BLACK, LAW DICTIONARY (4th ed. 1951). When a patient consents to an operation, he authorizes the physician to operate on his body. See Powell, *Consent to Operative Procedures*, 21 MD. L. REV. 189 (1961).

It is well settled that in the absence of an emergency, a physician must first obtain the consent of a patient before treating or operating on him. *E.g.*, Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1904); Schloendorff v. Society Hosp., 211 N.Y. 125, 105 N.E. 92 (1914), *overruled on other grounds*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3 (1957); Rolater v. Strain, 39 Okla. 572, 137 Pac. 96 (1913); Hively v. Higgs, 120 Ore. 588, 253 Pac. 363 (1927). The reasoning behind the rule was succinctly stated in *Schloendorff* by Judge Cardozo: "Every human being of adult years and sound mind has a right to decide what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages." Schloendorff v. Society Hosp., *supra* at 126, 105 N.E.-2d at 93. The rule recognizes that the consent may be implied under some circumstances, Mohr v. Williams, *supra* (recognizing but refusing to apply), and that the existence of an emergency may justify operating without any consent if immediate action is necessary to preserve the life or health of the patient. See, *e.g.*, Pratt v. Davis, 225 Ill. 300, 79 N.E. 562 (1906); King v. Carney, 85 Okla. 62, 204 Pac. 270 (1922).

[5] Gray v. Grunnagle, 223 A.2d 663 (Pa. 1966).

[6] *Id.* at 674. The court adopts the view expressed in Powell, *supra* note 4, at 193.

[7] 223 A.2d at 677. Parol evidence of prior oral or written negotiations or agreements of the parties to a written contract, which varies or contradicts the written contract, is generally inadmissible. For a thorough discussion of the rule and its ramifications, see 3 CORBIN, CONTRACTS §§ 573-96 (1960); SIMPSON, CONTRACTS §§ 98-101 (2d ed. 1965).

[8] 70 C.J.S. *Physicians and Surgeons* § 57 (1951).

eration on the patient, he may be liable if he cared for the patient without the latter's consent.[9] Consent is the patient's authorization to have his body touched by the physician,[10] and an operation without the consent of the patient or someone authorized to give it[11] constitutes a battery.[12]

A group of recent cases,[13] including the *Gray* decision, has somewhat modified the general rules concerning consent. It is required not only that a patient consent to an operation but also that the consent be "understandingly" given.[14] That is, prior to an operation, a doctor has a duty to inform his patient of the nature of his illness, the nature of the operation and possible risks involved, and the feasible alternative treatments so that the patient may intelligently decide whether or not he wishes the operation.

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[9] See representative cases cited note 4 *supra.*

[10] The nature of the patient's consent is discussed in note 4 *supra.*

[11] It has been said that a husband has no inherent power to consent to a dangerous operation for his mentally competent wife. Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906). However, when the wife has less than full possession of her faculties, the situation changes. *Ibid.*

Sound medical practice requires a doctor to obtain the parent's consent before operating on a minor child, but it has been held that a doctor may proceed with only the minor's consent. Bakker v. Welsh, 144 Mich. 632, 108 N.W. 94 (1906).

[12] *E.g.,* Moos v. United States, 225 F.2d 705 (8th Cir. 1955); Wall v. Brim, 138 F.2d 478 (5th Cir. 1943); Valdez v. Percy, 35 Cal. App. 2d 485, 96 P.2d 142 (Dist. Ct. App. 1939); Pratt v. Davis, *supra* note 11; Nolan v. Kechijian, 75 R.I. 165, 64 A.2d 866 (1949). The classification of the plaintiff's claim as one for battery rather than for negligence has many possible effects. In a battery action, there is no need to show any physical injury, damages being established by the unwarranted touching of plaintiff's body. See PROSSER, TORTS 33-34 (3d ed. 1965); RESTATEMENT (SECOND), TORTS § 18, comment *c* (1965). Also, punitive or exemplary damages are more likely to be awarded in a battery action than in an action based on negligence, because a battery is intentional. See PROSSER, *op. cit. supra.* at 9-10. Most significant, especially to plaintiffs, is that in a battery action the plaintiff may rely entirely on nonexpert testimony in contrast to the requirement in negligent malpractice cases that medical experts be used to establish the basic standard of conduct or deviation therefrom. See, *e.g.,* Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949); Hull v. Plumer, 131 N.J.L. 511, 37 A.2d 53 (1944). On the other hand, the plaintiff whose case is characterized as one in battery may find that he is unable to bring an action against the federal government under the Federal Tort Claims Act, 28 U.S.C. § 2680(h) (1964). See, *e.g.,* Moos v. United States, *supra.* It has been suggested that if the battery claim is based upon an unauthorized operation, it is so inconsistent with a negligence claim that the two may not be maintained in the same action. Cady v. Fraser, 122 Colo. 252, 222 P.2d 422 (1950).

[13] Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 560, 317 P.2d 170 (Dist. Ct. App. 1957); Di Filipo v. Preston, 53 Del. 539, 173 A.2d 333 (1964); Russell v. Harwick, 166 So. 2d 904 (Fla. App. 1964), *cert. discharged,* 182 So. 2d 241 (Fla. 1966); Bowers v. Talmage, 159 So. 2d 888 (Fla. App. 1963); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960); Bang v. Charles T. Miller Hosp., 251 Minn. 427, 88 N.W.2d 186 (1958); Mitchell v. Robinson, 334 S.W.2d 11 (Mo. 1960); DiRosse v. Wein, 24 App. Div. 2d 510, 261 N.Y.S.2d 623 (1965); Scott v. Wilson, 396 S.W.2d 532 (Tex. Civ. App. 1965).

[14] "Understandingly" is defined in the cases cited note 13 *supra.*

The consent required in these cases has been termed *informed* consent.[15]

Exactly what a physician must tell his patient prior to an operation to satisfy the duty of adequately "informing" is not well defined. A reading of the cases reveals various standards by which the courts determine whether a doctor has fulfilled his obligation to inform by: a reasonable disclosure;[16] a disclosure of any facts necessary to an intelligent consent;[17] or a disclosure to the extent that the profession recognizes a duty.[18] Despite the variety of standards, the means of determining whether a particular one has been met is common to all, namely, an examination of what the physician told his patient prior to the operation.

The court in the instant case, however, determined the critical issue to be not what the doctor actually *told* the patient prior to the operation but rather what the latter *understood* of what was explained to him. The opinion stated: " '[I]t will be no defense for a surgeon to prove that the patient had given his consent, if the consent was not given with a true understanding of the nature of the operation to be performed.' "[19]

To require the patient to have a "true understanding of the nature of the operation"[20] involves, at a minimum, the physician's apprising the patient of his pre-operative condition, the basic operative procedures, and any adverse consequences that might arise from the operation. In effect, this requirement subjects a physician to the possibility of a lawsuit if, in the exercise of his professional judgment, he withholds from the patient any information concerning the operation and its possible ramifications.

The desirability of judicially limiting the doctor's discretion in determining what facts to disclose prior to an operation is questionable. As indicated by its position, the court in the *Gray* case values such a limitation, although its reasons for imposing such a limitation are not clear because the policy grounds, if any, on which the decision rests are not enumerated. It is clear, however, that the

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[15] Morris, *Malpractice: Medical — The Important Events of the Last Two Years,* 30 INS. COUNSEL J. 44, 50 (1963); Oppenheim, *Informed Consent to Medical Treatment,* 11 CLEV.-MAR. L. REV. 249, 253 (1962).

[16] DiRosse v. Wein, 24 App. Div. 2d 510, 261 N.Y.S.2d 623 (1965).

[17] Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (Dist. Ct. App. 1957).

[18] Di Filipo v. Preston, 53 Del. 539, 173 A.2d 333 (1964); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960).

[19] Gray v. Grunnagle, 223 A.2d 663, 674 (Pa. 1966).

[20] *Ibid.*

court was compelled to choose between conflicting interests. Present in the case at bar were, on the one hand, the doctor's interest in the unrestricted exercise of his discretion[21] and, on the other, the patient's right to have his body secure from unwarranted touching.[22]

It is doubtful that the court in the instant case based its decision solely on the grounds that a patient has a right to be secure from unwarranted touching,[23] because it cannot be said with any candor that patients, as a group, are in any real peril of suffering battery.[24] The traditional battery involves a defendant who is acting for the most part out of malice or in a manner considered hostile,[25] whereas the usual[26] medical malpractice suit is brought against a doctor for an operation which was performed with the best interests of the patient in mind.[27]

Rather than attempting to insure patient security, the court's decision very likely represents an endeavor to stimulate physician-patient communication preceding an operation.[28] If so, this should be accomplished without seriously limiting a doctor's discretion con-

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21 According to one writer, the doctor's privileges should be conditional, in that his discretion should be limited in those situations where the patient would feel entitled to have the information as a basis for charting his future and where there are no grounds for supposing that a disclosure would engender reactions dangerous to the patient's health. Smith, *Therapeutic Privilege To Withhold Specific Diagnosis From Patient Sick With Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946).

22 Generally, the plaintiff in a battery action desires freedom from offensive bodily contact. See PROSSER, *op. cit. supra* note 12, § 9; RESTATEMENT (SECOND), TORTS § 18, comment *c* (1965). Bodily contact is actionable if it offends a reasonable sense of personal dignity. *Id.* § 19.

23 The physician-patient relationship has long been recognized as one of trust and confidence. The acme of such recognition is contained in Bennan v. Parsonnet, 83 N.J.L. 20, 83 Atl. 948 (1912) where, in order to find consent for the operation that had been performed, it was said that the physician was an agent for the anesthetized patient and could confer consent upon himself to perform the operation.

24 See cases cited note 12 *supra.*

25 See PROSSER, *op. cit. supra* note 12, § 9, at 34; RESTATEMENT (SECOND), TORTS § 16 (1965).

26 Minor exceptions do exist. See, *e.g.*, Keen v. Coleman, 67 Ga. App. 331, 20 S.E.2d 175 (1942) (physician causing a miscarriage over the protests of patient); Bartell v. State, 106 Wis. 342, 82 N.W. 142 (1900) (defendant, under pretense of giving massage treatment, examined and touched a young girl's naked body); *cf.* Byran v. Grace, 63 Ga. App. 373, 11 S.E.2d 241 (1940) (dentist engaging in hyper-sexual gestures).

27 *E.g.*, Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1904); Bennan v. Parsonnet, 83 N.J.L. 20, 83 Atl. 948 (1912); King v. Carney, 85 Okla. 62, 204 Pac. 270 (1922). In each of these cases, the physician was sued for removing dangers to the patient's health which were not anticipated at the diagnostic stage of the physician-patient relationship.

28 Such a conclusion logically flows from an examination of the inquiry which the court made in order to determine whether the plaintiff had consented to the operation — *i.e.*, did the patient "have a true understanding of the nature of the operation." Gray v. Grunnagle, 223 A.2d 663, 674 (Pa. 1966).

cerning pre-operative discussions, for there are some instances where it would not be good medical practice[29] to tell the "whole truth."[30]

Where full disclosure would create fright and nervous tension in an already alarmed patient, the physician should be allowed to employ his discretion and withhold what information he thinks advisable.[31] Furthermore, it is questionable whether a doctor can intelligently communicate the significance of certain facts or the weight to be given to his conclusions. Finally, the most cogent argument for keeping pre-operative discussions within the doctor's discretion is the impairment to medical progress that would result from the limitations placed thereon.[32] A "fully" informed patient, when confronted with a new technique, is liable to become unduly frightened and refuse to submit to what will generally prove to be an otherwise harmless and beneficial operation.[33] It is apparent that if this situation became commonplace, the progress of medicine would be severely restricted.

The court in *Gray v. Grunnagle*[34] could have protected the physician's discretion in pre-operative dealings and at the same time increased physician-patient communication. The question of whether a doctor has adequately informed his patient should not be determined by the patient's *understanding*[35] of what was told him, but rather should be determined by an examination of the physician's conduct in light of the particular *needs* of the patient. The inquiry should be whether a physician of similar standing in the community, having considered the patient's situation, would have justifiably concluded that the patient, if "fully informed," would not have withdrawn his consent.[36] This standard not only emphasizes the right of a patient to be "informed" concerning his operation but

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29 One writer maintains that an unnecessarily detailed analysis of the patient's case which alarms the patient may itself constitute malpractice. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 596-97 (1959).

30 The possibility that harm to the patient's interest might accrue from a disclosure of the "whole truth" was noted in Henderson, *Physician and Patient as a Social System*, 212 NEW ENGLAND J. MEDICINE 819, 823 (1935). The writer exhorts the doctor to "do no harm" rather than tell the "whole truth." *Ibid.*

31 See Oppenheim, *supra* note 15, at 251.

32 *Id.* at 261.

33 *Id.* at 251.

34 223 A.2d 663 (Pa. 1966).

35 *Id.* at 674.

36 For a general discussion of the standard of care to which the physician should comply, see Oppenheim, *Standard of Care of Medical General Practitioners*, 9 CLEV.-MAR. L. REV. 227 (1960); Schroeder, *The Standard of Medical Care* (pt. 1), 35 POST GRADUATE MEDICINE A75 (1964).

also preserves the doctor's discretionary processes by implicitly recognizing that situations[37] exist in which the doctor, employing the best practice, may choose to withhold some "facts" from his patient. The test calls upon the doctor to measure each case individually, drawing from his wealth of knowledge and experience, and to disclose those factors which he deems essential to an intelligent decision by his patient.

This proposed test, unlike that employed in the instant case, does not reward the patient who "guessed wrongly" concerning the meaning of what the physician told him prior to the operation. By virtue of the inquiry made by the court in the instant case, a patient who "guessed wrongly" could still be compensated because he did not have a "true understanding of the nature of the operation." Especially after a disappointing operation,[38] the patient would be extremely tempted to become "confused" as to what was told him prior to the operation. When a large reward from a sympathetic jury is contemplated, the temptation is even greater. In this respect there would seem to be some substance to the fear that the decision in the instant case "opens wide the door . . . to fraud"[39] and to increased malpractice litigation.[40]

The increasing number[41] of medical malpractice suits unfortunately involves, as has been contended,[42] many unwarranted claims. The physician can do much to reduce the number of malpractice suits by exercising reasonable care in following accepted methods of practice, keeping accurate and complete records of the patient's history, symptoms, treatment, and progress, and adopting a friendly attitude toward patients and fellow physicians.[43] The

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37 For illustrative situations, see text accompanying notes 31-33 *supra.*

38 It has been suggested that a good many cases involving unauthorized operations are brought by patients who are disillusioned by the result of the operation. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 426 (1957). See also Clephane, *Recent Trends in Malpractice*, 63 PA. MEDICAL J. 857 (1960).

39 223 A.2d at 676 (dissenting opinion).

40 *Ibid.*

41 The court system through which the instant case rose decided only twenty-four medical malpractice cases between 1834 and 1934, while between 1950 and 1960 alone, there were twelve cases decided. Clephane, *supra* note 38, at 857. Estimates of the number of medical malpractice suits filed yearly reach 6,000, the total cost of which is judged to be about $50,000,000. *Ibid.*

42 Berger, *Some Thoughts on a New Method of Reducing the Number of Malpractice Actions*, 92 MEDICAL TIMES 1292 (1964).

43 Means by which the physician might reduce the number of medical malpractice suits are noted in Clephane, *supra* note 38, at 864; Cockrell, *Suggestions for Avoiding Malpractice Suits*, 27 AM. SURGEON 152 (1961).