Torts – Negligence – Surgical Liability

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CASES NOTED

TORTS — NEGLIGENCE — SURGICAL LIABILITY

Plaintiff was injured by the physician’s administration of an anesthetization procedure which the plaintiff had expressly prohibited. The jury found that no emergency existed and judgment was awarded for the plaintiff. Held, affirmed, an action for a technical trespass lies where a physician acts contrary to the patient’s express prohibition in the absence of an emergency situation. Chambers v. Nottebaum, 96 So.2d 716 (Fla. Ct. of App. 1957).

At the common law, the patient’s express consent was necessary for the performance of any surgical operation. The only exception to this rule was in cases termed emergency situations. The exception was based upon implied consent. It has been contended, however, that a more accurate description would be that a physician, by reason of the emergency, is privileged to act as though consent had been given.

Upon the widespread use of anesthetics which render the patient unconscious, another class of cases began to arise. The physician, after having undertaken an authorized operation, sometimes met with unanticipated conditions or reactions on the part of his patient which required, or at some future time might require, additional surgery. The patient’s unconscious condition prevented him from giving express consent to the action found necessary by the surgeon, and the surgeon sometimes rendered the unauthorized treatment of his own accord. In most cases arising as a result of unauthorized extensions of authorized surgery, courts have held the com-


2. Where some immediate action is found necessary for the preservation of the life or health of the patient and it is impractical or impossible to first obtain consent to the operation which the surgeon deems to be immediately necessary. Cotnam v. Wisdom, 83 Ark. 601, 104 S.W. 164 (1907); Wheeler v. Barker, 92 Calif. App. 2d 776, 208 P.2d 68 (1949); Tabor v. Scoobee, 254 S.W. 2d 474 (Ky. 1951) (mere endangering of life sometime in the future is not an emergency raising implied consent); Bennan v. Parsonsnett, 83 N.J. L. 20, 83 Atl. 948 (1912) (imminent threat to life or grave or irreparable injury to health); Barnett v. Bachrach, 34 A.2d 626 (D.C. Mun. App. 1943) (emergency must endanger life at present moment).

3. Where there is an emergency, it may be implied that the patient consents to the exercise of emergency treatment. Cases cited at note 2 supra. See also Mohr v. Williams, 95 Minn. 263, 104 N.W. 12 (1905) (where application of doctrine is discussed but not employed); 70 C. J. S. 967 Physicians and Surgeons § 48 (1951).

4. Prosser, TORTS § 18, p. 84 (2d ed. 1955).

5. The first widespread use of ether anesthetization began in about 1846. I ENCYC. BRIT. 862 (1951).

6. Wall v. Brim, 138 F. 2d 478 (5th Cir. 1943) (held a battery where for an operation to remove a small cyst, the physician removed a large cyst); Church v. Adler, 350 Ill. App. 471, 113 N.E. 2d 327 (1953) (held a battery where physician remove inflamed appendix during an operation for the removal of diseased ovaries); Franklyn v.
mission of a technical trespass, relying on the same common law rule as set out above — that a physician operates at his peril when he does not first obtain the patient’s express consent or that of the patient’s parent if the patient is a minor. The rule is qualified in this class of cases, too, by the existence of an emergency situation.

It was recognized in the early part of this century that the introduction of anesthesia into the practice of surgery had modified application of the common law rule in certain fundamental respects of which the law must take notice. Before setting forth the several theories which have been advanced in an effort to better adapt the law to the requirements of modern surgery, it might prove helpful to examine the cases which give rise to technical trespass suits against physicians.

The cases appear to fall into three separate groups: First, there are the strict emergency cases, arising either out of an accident or during the course of an authorized surgery. Second, there are the cases in which a physician discovers, during the course of an authorized surgery for the correction of a particular set of symptoms, that additional or different causes from those contemplated are responsible for the patient’s symptoms and condition. For purposes of this discussion, we shall label these latter cases as the “symptomatic” class. The third class of cases involve the physician’s discovery, during the course of authorized surgery, of additional conditions, not contributing to the symptoms of which the patient complained, but which, in the physician’s best professional judgment, should be remedied at

Peabody, 249 Mich. 363, 228 N. W. 681 (1930) (held a battery where physician, upon discovery of unexpected condition, made small skin graft in correcting stiffness of finger); Mohr v. Williams, 95 Minn. 263, 104 N. W. 12 (1905) (held a battery where physician operated upon a more serious condition in the left ear in addition to a condition of the right ear the correction of which patient had consented to); Hively v. Higgs, 120 Ore. 588, 253 Pac. 363 (1927) (held a battery where physician removed tonsils during operation on septum).

7. Cases cited note 6 supra.
8. Jackovach v. Yocum, 212 Iowa 914, 237 N. W. 444 (1931) (where parent could not be contacted in emergency, consent was implied); Wells v. McGee, 39 So. 2d 196 (La. App. 1949) (where parent could not be contacted in emergency, consent was implied).
9. “The scope of modern surgery has been enlarged; legal rules must extend beyond emergencies of actual surgery to other matters more or less vitally affecting the patient’s welfare. To meet these changed conditions, the rule of law must, in the interest of doctor and patient alike, be adapted to the changes which have been wrought.” Bennau v. Parsonnett, 83 N. J. L. 20, 83 Atl. 948 (1912).
12. Wall v. Brim, 138 F. 2d 478 (5th Cir. 1943) (Small cyst anticipated but large cyst discovered and removed); Bennau v. Parsonnett, 83 N. J. L. 20, 83 Atl. 948 (1912) (Rupture anticipated on left side was more serious on right side).
the moment, not for reasons of emergency but because the moment is opportune.13 Let us label this group of cases as the "additional condition" group.

With reference to the emergency class of cases, the use of the doctrine of privilege14 seems to best satisfy the situation. It requires little rationalization nor the use of implied consent to allow a physician the privilege of saving life or acting to prevent "grave or irreparable injury to health" in an emergency situation.

The remaining two groups of cases present different problems, both of which appear to be susceptible of better solution than that of the application of the doctrine of implied consent. The latter doctrine does not seem fairly applicable where the extension is made for reasons of good surgery, convenience to the patient or remediying the symptoms complained of rather than to meet an emergency. The use of implied consent in such instances is simply a case of applying the wrong tool, one no more suited to its purpose than the use of a screwdriver to hammer a nail. Some of the decided cases are expressive of better solutions to the second and third problem areas. It has been suggested that a patient who voluntarily submits himself to a surgeon for treatment, relying entirely upon the surgeon's skill and care, gives a general consent to such operation as may, in the surgeon's skill and professional judgment, be reasonably necessary.15 The broad consent inherent in the application of this rule is sufficient to cover both the symptomatic and additional condition cases. A recent law review comment advocates, too, the test of reasonableness in cases of unauthorized extensions.16 This test is the broadest and most flexible one that might be used. Its prime criticism is that it places too much discretion in the hands of a surgeon. To meet this assault it must be pointed out that the test would have little effect where the patient expressly prohibited treatment or operative measures beyond that to which he expressly consents. A complete disclosure and discussion by the surgeon and his patient of the patient's condition and the forthcoming operation would go far toward eliminating misunderstanding (and law suits) on the part of each.

In Kennedy v. Parrott,17 the court permitted extension to remedy an abnormal or diseased condition within the area of the original incision.18 This particular device might be helpful in certain cases, but seems limited

14. See note 4 supra.
15. King v. Carney, 85 Okla. 62, 204 Pac. 270 (1922) (Physician made exploratory incision and discovering Fallopian tubes infected removed them. Held not a trespass. After suggesting the rationale set forth in the text, infra, the court attempted to justify its holding by finding an implied consent and hinting at the existence of an emergency. A finding of express, general consent would appear to have been more sound.).
18. Id. at 362, 90 S. E. 2d at 759.
in some respects. It is inapplicable, of course, to the instant case and others like it where no actual incision was involved, but rather a pre-operative anesthetization procedure. In addition, it does not appear to allow for an extension of the original incision even for the purpose of remedying the symptoms for which the operation is being made.

The *Kennedy* case seems to suggest two other alternatives. The first is that the surgeon may make any reasonable extension which is in accord with good surgical practice. This would answer the criticism to the first test suggested in the case and seems more closely allied with the test of reasonableness already discussed. The second suggestion is that the patient may be taken to have consented to any surgery which will relieve him of the afflictions with which he is suffering. This latter suggestion seems to be a highly realistic one in the sense that most patients complain of symptoms rather than specific ailments or conditions. This method would appear to be the best solution to the symptomatic group of cases. The test seems to be specific enough to restrict its use to that class of cases. There would be no confusion in applying the policy to cases which fall into either the emergency or additional condition groups.

The greatest problem, then, lies in the solution of the additional condition cases. The best available solution to this group of cases is probably the application of the test of reasonableness. Some extensions would unquestionably be unwarranted and in such cases there would certainly be misconduct on the physician’s part amounting to technical trespass. There might be other cases, however, in which the extension is reasonable and in accord with good surgery. In the latter cases not only is no harm done, but, quite to the contrary, a benefit and convenience has been conferred upon the patient.

Any of the proposed theories under which a surgeon’s liability for an extension might be determined must be examined in terms of the patient’s right to be protected.

“Under a free government, at least, the free citizen’s first and greatest right, which underlies all others — the right to the inviolability of his person; in other words, the right to himself — is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent . . . . to violate, without permission, the bodily integrity of his patient . . . .”

In the *Chambers* case, Florida becomes another of the states giving respect to the common law rule which requires express or implied consent

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19. For an interesting discussion of the case see note, 6 Duke L. J. 41 (1957).
21. Id. at 363, 90 S. E. 2d at 760.
to surgery. The facts of the instant case made it unnecessary to decide the application of any other rule but that of absolute consent. A physician will always be held liable where he extends an operation in contravention of the patient's express prohibition and in the absence of an emergency situation.

Here, the patient had expressly prohibited the use of a spinal anesthetic. When the patient reacted convulsively to the administration of sodium penathol, the physician directed the use of a spinal anesthetic which application caused an injury to the patient's leg. The jury was instructed in the application of the strict consent theory and the exception arising under the emergency situation. Although there was some conflict in testimony concerning the acuity of the patient's condition, the jury found that no emergency existed.

The decision in the instant case seems proper in the case of an extension expressly prohibited by the patient. It appears to be a rule which will go unchanged. The mitigating emergency doctrine is available to prevent unjust results. In situations where there is no express prohibition, however, it is to be hoped that Florida will adopt a solution which is better adapted to the changes which have come about in modern surgery.

The doctrine upon which the common law rule is based has in modern times becomes very much a fiction. It is an affront to the intelligence of the most liberal to maintain that a patient could possibly give his express consent specifically to each of the myriad processes involved in even the simplest surgery. It is more obviously a fairy tale to speak in terms of implied consent. The use of one or a combination of the suggestions advanced earlier, or others which may have been neglected, would go far toward eliminating the necessity of dealing with the ghost of implied consent.

The instant decision is in no way inconsistent with the use of any of the suggested solutions in cases of extensions of surgery which may arise. It may be hoped that, in the event such a situation does arise, the Florida courts will meet the challenge with a solution better geared to the realities of medical progress and practice than the rule still in vogue in most jurisdictions of the United States.

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25. For an interesting discussion of the application of res ipsa loquitur in injury suits resulting from spinal penetrations in administration of anesthesia see comment, 6 Clev.-Mar. L. Rev. 461 (1957).
27. Id. at 720.