Consent

William J. Joost

Follow this and additional works at: https://scholarship.kentlaw.iit.edu/cklawreview

Part of the Law Commons

Recommended Citation
Available at: https://scholarship.kentlaw.iit.edu/cklawreview/vol44/iss2/6

This Article is brought to you for free and open access by Scholarly Commons @ IIT Chicago-Kent College of Law. It has been accepted for inclusion in Chicago-Kent Law Review by an authorized editor of Scholarly Commons @ IIT Chicago-Kent College of Law. For more information, please contact dginsberg@kentlaw.iit.edu.
court held, regardless of school of medicine followed, the standard of care was that, "a physician and surgeon use that degree of professional knowledge, skill and care which the average physician and surgeon would ordinarily bring to a similar case under like circumstances in that locality." 9

Since this standard of care applies to all practice of medicine in Illinois, the problem is to determine what the practice of medicine is. Osteopathy has been referred to as the practice of medicine 10 and osteopaths are considered to be physicians if practicing with a license. 11 Although the premise of osteopathy is that human ailments are caused by the pressure of displaced bones on nerves and can be cured by manipulation, osteopaths will be presumably judged by the universal standard of care that is applied to physicians and surgeons. 12 Furthermore, any attempt at treatment outside the limits of an osteopathic license subjects them to liability as an unqualified person. 13

A similar standard is applied to chiropractors since chiropractic treatment has been legislatively defined as the practice of medicine. 14

Naprapaths, who consider human ailments to be the result of strained or contracted ligiments, have been judicially defined as practitioners of a system of massage 15 and not practitioners of medicine. 16 Therefore, they will not be judged by the same standard as those practicing medicine but will be liable as an unqualified person. 17

William J. Joost

CONSENT

The relationship that exists between a physician and patient can probably be best described in the civil law term of consensual contract. That is, a contract springs into existence through a mutual manifestation of consent without the need for any formal offer, acceptance or consideration.

Despite the fact that no formalities are necessary, one essential element must be present—consent. The physician exposes himself to suits for technical batteries by treating a person without consent or in excess of

9 Supra note 7, at 379.
10 People ex rel State Board of Health v. Gordon, 194 Ill. 560, 62 N.E. 858 (1902).
11 People ex rel Cage v. Simon, 278 Ill. 256, 115 N.E. 817 (1917).
12 Supra note 7.
13 Williams v. Piontkowski, 337 Ill. App. 101, 84 N.E.2d 843 (1st Dist. 1949). Thus, the chiropractor or osteopath is faced with the dilemma of being judged by the principles of physicians and surgeons if he practices within the confines of his license or goes beyond it.
17 Supra note 13.
consent given. The reason for such liability was expressed by Judge Cardozo: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault [sic-battery] for which he is liable in damages."  

If it can be shown that a legally competent person has given actual and informed consent to a specific operation or medical treatment no liability for battery will arise. Legal controversey has largely been over such questions as: Must consent be express or may it be implied from circumstances? Is consent required in an emergency situation? Whose consent must be obtained? What is "informed consent?"

**IMPLIED CONSENT**

Consent does not have to be express. It can be implied from circumstances. "The patient may by his whole course of conduct, without the use of any express language giving consent, evidently place his body at the entire disposal of the surgeon or physician whom he consults."  

The existence of implied consent is one of factual determination. This determination encompasses all of the circumstances. Of prime importance is what the patient said and did. An example is *Gould v. Kerlin.* In that case, the patient presented herself to the defendant surgeon after a full outline of the intended operation had been sent to her family physician and, in turn, explained to her. She never expressly consented to the operation. In finding for the defendant, the court held that the plaintiff's actions were sufficient to manifest consent. These actions consisted of submission to the physician, with full knowledge of the operation, and failure to protest in any manner. Thus, the defendant was justified in relying on the plaintiff's overt actions and not obliged to search for unexpressed feelings.

Implied consent has been raised as a defense in cases where the defendant doctor, after receiving express consent for a specific operation, extends its scope to another malady discovered during the operation. For example, the doctor, while performing an appendectomy, may discover cysts on the patient's ovaries and proceed to puncture the cysts. The rationale

---

3. Pratt v. Davis, 224 Ill. 300, 305, 79 N.E. 562, 564 (1906). The broad statement of "entire disposal" is limited greatly by later statements in the case. See generally, Prosser, Torts § 18 (3d ed. 1964).
of the defense is that the extension was for the benefit of the patient and the result of sound medical judgment. Even though a true emergency did not exist, the patient had selected the surgeon to improve her physical condition and, therefore, since the extension was beneficial, the patient had impliedly consented to it.

Illinois courts have seemingly rejected this defense. In *Church v. Adler*, the patient had consented to a total hysterectomy. The defendant also removed her appendix. Without any discussion of implied consent, the court held that, "The surgeon's removal of the patient's appendix without her consent is a tort." In *Beringer v. Lachner*, the plaintiff had consented to a vaginal curettage or scraping. After she had been anesthetized, the surgeon performed a vaginal hysterectomy. He testified that certain conditions were present which he had previously not known, and that further prognosis in light of these factors indicated that a vaginal hysterectomy would afford a better medical result. The court stated, "It is our view that, on this question of law, plaintiffs are entitled to the inference . . . that the hysterectomy was performed without consent. We cannot hold as a matter of law that the hysterectomy was discretionary in Dr. Lachner's duty to the patient." Also, by way of dicta in *Pratt v. Davis*, after discussing medical obligations owed to the patient, the court stated, "[T]hey do not confer on the surgeon or physician unlimited powers to use his own discretion in the surgical or medical treatment of patients. . . ."11

The liberal view of implied consent accepted in other jurisdictions should be viewed with reference to the three above Illinois cases. A New Jersey decision held that the use of general anesthesia in surgery causes the surgeon to be the agent of the patient during the period of unconsciousness. As a result of this agency, the surgeon has the authority to extend an operation, after exploratory surgery, to correct the original malady. Likewise, a California appellate court held that a broad written consent giving the physician the power to perform all treatments deemed advisable was sufficient to cover surgical removal of part of the Fallopian tubes during an appendectomy, even though no immediate danger existed. It seems probable that Illinois courts would not accept these decisions as persuasive authority.

**Emergency**

A true emergency situation, which endangers the life or health of the patient, obviates the necessity for obtaining consent. The surgeon is free

---

8 supra note 7, at 483, 113 N.E.2d at 332.
10 supra note 9, at 595, 73 N.E.2d at 622.
to operate without any fear of civil liability. It has been said that consent is implied under the circumstances.\textsuperscript{14} The more accurate approach is to say that the physician is privileged.\textsuperscript{15}

The emergency situation is well outlined in an Iowa case, \textit{Jackovach v. Yocom}.\textsuperscript{16} A minor patient had been severely injured in leaping from a moving train. Comminuted fractures of the elbow and deep lacerations of the forearm made the injury extremely susceptible to gangrene. Sound medical judgment dictated that the arm be amputated to prevent such an infection. The boy was unconscious and his parents could not be located, which necessitated that the surgeon proceed without obtaining consent. The court held that the physician could proceed under such circumstances without consent. Therefore, in an emergency, the physician can do what the occasion demands. The preservation of life and health outweighs the necessity for consent.

The emergency privilege has sometimes been applied to unauthorized extensions of operations.\textsuperscript{17} In these cases, an unforeseen emergency developed which was critical in nature. Extension of the original operation was necessary to preserve the patients' health. The theory in extending the operation being that the patient would have consented if he were conscious and understood the situation.

Illinois courts have not dealt with the privilege of defense when the emergency gave rise to the initial physician-patient contact as in the \textit{Jackovach}\textsuperscript{18} case.

Likewise, unforeseen emergency has not been considered as a defense in extending an operation without consent. However, in light of the court's statement in \textit{Beringer v. Lachner},\textsuperscript{19} Illinois courts would require strict proof that a critical situation had been discovered, thereby, not allowing physicians wide latitude to extend operations on the basis of their personal judgment and discretion.

\textbf{WHO MUST CONSENT}

A question sometimes arises as to whose consent must be obtained. In most situations, the consent of the patient is necessary.\textsuperscript{20} However, if the patient is incapable of giving consent because of infancy,\textsuperscript{21} or mental in-

\textsuperscript{14} Prosser, Torts § 18 (3d ed. 1964).
\textsuperscript{15} Restatement, Torts § 62 (1938).
\textsuperscript{16} 212 Iowa 914, 237 N.W. 444 (1931).
\textsuperscript{17} Delahunt v. Finton, 244 Mich. 226, 221 N.W. 168 (1928). See supra note 15.
\textsuperscript{18} Supra note 16.
\textsuperscript{19} 331 Ill. App. 591, 595, 73 N.E.2d 620, 622 (3d Dist. 1947). Cf., Pratt v. Davis, 118 Ill. App. 161, 166 (1st Dist. 1905), aff'd., 224 Ill. 300, 79 N.E. 562 (1906) (Dictum) "We do not hold, ... that there is 'a universal acquiescence of lay and professional minds in the principle that the employment of the physician or surgeon gives him implied consent to do whatever in the exercise of his judgment may be necessary.'"
\textsuperscript{20} Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).
\textsuperscript{21} Bonner v. Moran, 126 F.2d 121 ( Ct. App. D.C. 1941).
competence his failure to object, or even his active assent, will not shield the practitioner from liability.

When the patient is insane, delerious, or unconscious, consent may be obtained from a near relative. Before the necessity for personal consent will be waived the patient's mental condition must be such that he lacks the ability to give a rational consent.

In *Pratt v. Davis*, the defendant surgeon had represented to the patient and her husband that the intended operation would be slight. After the patient had been anesthetized, the defendant removed her uterus and ovaries. No express consent had been obtained from the patient. The defendant stated that he did not feel that she was mentally competent to give consent. His defense was that consent had been obtained from her husband. The court held that the burden of proving the lack of patient's mental capacity to consent is on the defendant-surgeon and his decision on the matter must be supported by the factual situation, in the light of expert testimony, and not based on his unsupported discretion. The fact that the defendant "did not think her mental condition was sufficient for advisement" is not enough to meet this burden of proof. Consequently, any consent given by the husband did not negate liability.

The court, by way of dicta, said that if the wife had been shown to be incompetent the husband's consent would have been sufficient and necessary. But, absent a factual showing incompetency, the spouse's consent is of no avail. In fact, the court was very careful not to establish a broad rule concerning the husband's authority in such cases to control medical treatment of his wife. The court said, relying on a Maryland case for persuasive authority, that no husband has the right to forbid or permit an operation, when his wife is mentally competent and has expressly consented to or forbid the operation.

Consent to operate on minors must, in general, be obtained from their parents. Minors approaching maturity have been held to have sufficient capacity to consent to minor operations. This reasoning has not, as of yet, been extended to major surgery.

22 *Supra* note 20.

23 *Ibid.* See also, Littlejohn v. Arbogast, 95 Ill. App. 605 (3d Dist. 1900). This case indicates that the physician may even use force to treat a delirious patient in cooperation with consent of relatives.

24 *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906).


28 State *ex rel* Janney v. Housekeeper, 70 Md. 162, 16 Atl. 382 (1889).

29 *Supra* note 26, at 171.

30 Bonner v. Moran, 126 F.2d 121 (Ct. App. D.C. 1941); see 20 Chi-Kent L. Rev. 357 (1942).

31 Lacey v. Laird, 166 Ohio St. 12, 159 N.E.2d 25 (Sup. Ct. 1956).
There are no Illinois decisions concerning minors' consent to medical treatment. Despite the lack of judicial treatment, certain statutory provisions have been passed in Illinois concerning consent of minors. Married minors or pregnant women, who are minors, may consent to medical treatment upon themselves. Further statutory protection has been given to physicians who obtain permission from a minor parent to give medical treatment to a son or daughter. In none of the above situations is the consent obtained voidable.

"INFORMED CONSENT"

An area of consent that has received much recent attention is that of "informed consent." One of the ways a technical battery may arise is when the patient's consent was obtained by fraud. The fraud relied on has been either misrepresentation of the very nature and character of the operation or a misrepresentation of collateral matters, such as undesirable consequences of the operation. Such fraud can result from active misrepresentation or from a failure to speak because of the trust and confidence placed in physicians by their patients.

An example of active misrepresentation is found in a Nevada case. The plaintiff had signed a written consent for a masectomy. Prior to signing the consent, she had been told by the surgeon, upon inquiry, that he had no intention of removing her breast. During the operation her breast was removed. She was not aware of the meaning of masectomy. The court held that the defendant's fraudulent conduct voided the consent and that a cause of action for battery, therefore, existed.

It has been held that a surgeon was liable for battery in failing to disclose undesirable consequences of an operation to a patient. The patient, suffering from a prostate infection, submitted to an operation, which included severance of the spermatic cords as part of the procedure. The plaintiff contended that his consent was vitiated since he was not told that he would be permanently sterile. The court held that a cause of action existed, because the plaintiff should have been made aware of the undesirable effects and thus been able to make an informed choice between having or not having the operation performed.

The second group of informed consent cases involves the following issue: whether a doctor, due to the trust and confidence that patients place in him, is under a duty to disclose risks of treatment and whether failure to disclose risks will be negligent.

36 Taber, Cyclopedic Medical Dictionary, p. M-10, defines masectomy as, "Excision (removal) of the breast."
This issue was raised in a 1960 Missouri case, *Mitchell v. Robinson*. In that case, the patient had agreed to undergo insulin shock therapy to attempt a cure of a schizophrenic condition. During treatment, a convulsion occurred and the plaintiff suffered compression fractures of several dorsal vertebrae. Expert testimony established that one of the unpredictable consequences of insulin therapy is that an unpreventable convulsion occurs, often causing severe injuries. The court held that due to the high incidence of injuries and the newness of the procedure, the doctor owed a duty to the plaintiff to disclose the possible risks.

*Mitchel v. Robinson* and several cases like it hold that the failure to disclose the possible risks of surgery is a matter of negligence and not a battery.

Since negligence is the cause of action, expert testimony is necessary to establish a standard of care under the circumstances and to determine whether it was met. The standard of care in these circumstances is not one of accepted medical treatment of the malady but, rather, what amount of information concerning the treatment must be conveyed to the patient. Various measuring sticks have been proposed: "reasonable disclosure," a "certain amount of disclosure consistent with the full disclosure of facts necessary to an informed consent," "substantial disclosure," and "no disclosure."

At first glance these four standards seem to cause an irreconcilable conflict. But, a central thought underlies all of the decisions. The physician must use sound judgment consistent with that used by a reasonably prudent physician in the same locality if faced with a similar medical problem and patient. With this viewpoint in mind, the various terms referring to disclosure become understandable. The duty of informing a patient of risks can run the gamut from complete disclosure to no disclosure depending on the mental attitude of the patient, the incidence of risk, the novelty of the treatment and the necessity for treatment. All of these criteria are to be examined in the light of expert testimony to determine whether the physician fulfilled his duty.

There are no cases in Illinois specifically referring to the concept of "informed consent." However, in *Pratt v. Davis* the court said, even if

38 334 S.W.2d 11 (Mo. Sup. 1960).
39 Ibid.
44 Supra note 41, at 401, 350 P.2d at 1103.
the husband's consent would have been proper under the circumstances, it was still not sufficient. He had not been advised of the true scope of the operation and consequently his consent was based on the defendant's misrepresentation. It seems likely, therefore, that the court would have accepted these circumstances to either totally vitiate the consent and hold the defendant liable for a technical battery or consider that the consent was a result of inadequate disclosure and hold the defendant liable in negligence.

WILLIAM J. JOOST

EXTENT OF THE VICARIOUS LIABILITY OF A PHYSICIAN OR SURGEON

Medical procedure usually requires the skills of many individuals. When a patient is injured by the negligent acts of an individual whose participation is required, there may be both direct and vicarious liability. It is clear that a physician or surgeon is liable for his own negligence. At issue is the extent of his liability for the negligence of others whose skills are needed.

Vicarious liability is that which is ascribed to a master, employer or principal for the tortious acts of his servant, employee or agent. This vicarious or imputed liability is grounded in the doctrine "respondeat superior." The doctrine was first enunciated by Chief Justice Holt in the case of Jones v. Hart, "The act of a servant is the act of his master, where he acts by authority of the master."1

The topic that will be discussed here is vicarious liability, or respondeat superior, as another aspect of a physician's or surgeon's liability in an action for medical malpractice.2

The vicarious liability of physicians and surgeons follows the general principles of agency. "A physician or surgeon is responsible for the negligent acts or omissions of his employees or agents while acting within the scope of their employment or agency."3

In the usual respondeat superior cases, the more frequently litigated questions are whether there is a master-servant relationship, and whether the servant was acting in the scope of his employment. In medical malprac-

2 The reasons for imputing the negligent acts and corresponding liability of a servant to his master are varied. Thomas Baty has discussed the underlying rationale in his book Vicarious Liability, Clarendon Press, Oxford, England (1916). In discussing the justification for the rule, Mr. Baty reviews several arguments. Among these are the argument from profit, the argument from identification, the argument from carefulness, the argument from control, and the argument from the "deep pocket," which is based on the idea that servants are an impecunious race.