Consent to Operative Procedures

Robert E. Powell

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CONSENT TO OPERATIVE PROCEDURES

By Robert E. Powell*

INTRODUCTION†

The law is reasonably well established that, before a physician or surgeon may operate upon or treat a patient, he must, in one form or another, obtain the consent of the patient, if he is mentally capable of giving it, or, if not, of his guardian, unless the circumstances are such that they demand immediate attention for the preservation of his life, limb or health.1 The basic concept behind the legal requirement that there be consent to operative procedure is, as expressed in Rolater v. Strain,2 that:

"Under a free government at least, the free citizen's first and greatest right, which underlies all others

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1 McClees v. Cohen, 158 Md. 60, 67, 148 A. 124 (1930); State v. Housekeeper, 70 Md. 162, 16 A. 382 (1889); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Tabor v. Scobee, 254 S.W. 2d 474 (Ky. 1951); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905); Rolater v. Strain, 39 Okla., 572, 137 P. 96 (1913); Smith, Antecedent Grounds of Liability in the Practice of Surgery, 14 Rocky Mt. L. Rev. 238 (1942); Note, Surgical Operations Without Consent, 19 Tenn. L. Rev. 374 (1946); Note, Consent as a Prerequisite to a Surgical Operation, 14 Cinn. L. Rev. 161 (1940); Note, Surgeon's Liability for Operation Without Patient's Consent, 26 Mich. L. Rev. 561 (1928).

2 39 Okla. 572, 137 P. 96 (1913).
— the right to the inviolability of his person, in other words, his right to himself — is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent, who has been asked to examine, diagnose, advise and prescribe . . . , to violate without permission the bodily integrity of his patient by a major or capital operation, placing him under anaesthetic for that purpose, and operating on him without his consent or knowledge.\(^8\)

In short, an unconsented to touching of another person's body constitutes a tort.\(^4\)

Normally consent acts as an absolute bar to an action in tort based on an improper touching of one's body.\(^5\) However, there are certain types of cases wherein it constitutes no defense for a physician or surgeon to prove that his patient consented.\(^6\) Conversely, there are cases wherein it is immaterial whether or not consent was given.\(^7\) However, in the vast majority of cases there must be consent in one form or another. There are three forms of consent: express,\(^8\) implied in fact,\(^9\) and implied in law.\(^10\)

\(^8\)Id., 97 quoting verbatim 37 Chicago Legal News 213. See also Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 165 N.E. 92, 93 (1914) wherein the court said:

"Every human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

\(^9\)See discussion of illegal operations, infra, circa, ns. 90-96.

\(^10\)See discussion on operations required, by law, infra, circa, ns. 13-16.

\(^11\)Luka v. Lowrie, 171 Mich. 122, 136 N.W. 1106 (1912). From the cases it is very difficult to ascertain in what instances consent is implied in
that, consent whether express or implied may be either
general or restrictive in nature, or its nature may be deter-
mimed by some special circumstance which either brought
the patient to the physician or arose after surgery had
been undertaken.

In order to understand the nature of consent it is neces-
sary at the outset to have some understanding of the legal
relationship between the physician and his patient. This
relationship is essentially contractual in nature.¹¹ More
often than not the contract is raised by implication from
the dealings between the parties, and in a like manner the
acts to be performed by the parties are impliedly defined.
Thus, if a patient consults a surgeon for the purpose of
removing a tumor from his arm, a contract is entered into
which requires the surgeon to remove the tumor. There-
fore, he must not digress from that contract and also
remove the patient's appendix. In short, the surgeon must
operate in accordance with the agreement made between
the parties. Consent for the operation or treatment arises
from the contract and is given only in connection with
what the parties understood was to be done. Thus, in the
illustration above, the patient did not consent to the per-
formance of any operation other than the removal of the
tumor, and if the surgeon removed the appendix as well,
he would be liable in damages. It is noted that in such a
case the patient might well rely on an action for breach
of contract.¹² However, he may base his action on a tortious
assault and battery and recover punitive damages which
are not available in contract actions.

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¹¹ Angulo v. Hallar, 137 Md. 227, 232, 112 A. 179 (1920); Findlay v.
Board of Sup'rs of County of Mohave, 72 Ariz. 58, 230 P. 2d 526 (1951);
Cartwright v. Bartholomew, 83 Ga. App. 503, 64 S.E. 2d 323 (1951);
Smith, 276 App. Div. 9, 92 N.Y.S. 2d 794 (1949); Helms v. Day, 215 S.W. 2d
356 (Tex. 1948).

¹² Robins v. Finestone, id., Angulo v. Haller, id., 232, where the court,
quoting from Dashiel v. Griffith, 84 Md. 363, 35 A. 1094 (1896), said:
"[T]hat a physician or surgeon who holds himself out to the world
to practice his profession, by so doing impliedly contracts with those
who employ him, that he possesses a reasonable degree of care, skill,
and learning, and he is, therefore, bound to exercise and is liable for
the want of reasonable care . . . ."

It was there indicated that the surgeon could be held liable on a theory of
breach of warranty of contract, or for tort. It is noted, however, that the
legal test for breach of warranty in this instance is the same as that
for negligence, i.e., whether the surgeon acts with reasonable care.
It is the purpose of this article to explore the various forms and natures of consent and the legal doctrines which have developed in relation thereto, and to illustrate those areas in which difficulties most often arise. It is hoped that some clarity will result as to the law in those areas in which physicians and surgeons have shown serious concern.

**Operations Required by Law**

Despite the Equal Protection Clause of the Constitution of the United States, the several states may require that certain operations be performed in order to protect society as a whole.\(^3\) Thus, the Supreme Court has upheld the validity of laws making it mandatory that an individual be vaccinated,\(^4\) and under special circumstances be sterilized.\(^5\) Similarly it has been held that a state may require that prostitutes be examined in order to protect the public from venereal diseases.\(^6\) In such cases the patient has no right either to give or refuse consent, but might have a right to choose the doctor who is to perform the operation or examination. The law itself provides the necessary consent for the performance of the operation, and in many instances makes it mandatory that the operation be performed and imposes a criminal penalty for failure to comply. Therefore, where a state law validly requires the performance of an operation, there is no consensual problem.

**Express Consent**

There is little difficulty in regard to consent, if the patient, either on his own initiative or by solicitation at the instance of a physician or a nurse consents either in writing or verbally to the undertaking of operative procedures in an attempt to remedy the pathological condition of which he complains. As indicated, express consent can be obtained either by having the patient sign a written statement or through the making of an oral agreement. In either case, since the agreement between the physician and his patient is contractual in nature, for there to be valid consent it must be clear that both parties understand the nature of the undertaking and what the possible


\(^4\) Jacobson v. Massachusetts, id.

\(^5\) Buck v. Bell, supra, n. 13, 207, where the Court said: "The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes . . . . Three generations of imbeciles are enough."

as well as expected results might be. As will be more thoroughly discussed later, it 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, the seriousness of it, the organs of the body involved, the disease or incapacity sought to be cured, and the possible results.¹⁷

**IMPLIED CONSENT**

There are many instances in which it is impractical to obtain express consent, and yet consent will arise by implication from the circumstances. Typical situations in which consent to operative procedures may be implied are where: (1) a patient on consulting a physician or surgeon fails to expressly request the specific treatment or operation deemed desirable, but also does not raise any objection thereto;¹⁸ (2) a surgeon, in performing an operation for which consent was given and while the patient is under anaesthesia, finds a related operation also desirable and deems it expedient to proceed with both operations;¹⁹ and (3) while performing a major operation, he discovers a situation which can be cured or remedied by minor surgery and deems it wise to proceed.²⁰ Interrelated with the question as to whether consent can be implied in cases such as those mentioned above, is the question as to how long consent, once given, will continue, and when consent has been exhausted or surpassed.

### 1. Request of Medical Assistance

Under the law, when a patient goes to a physician or surgeon and submits himself for examination, diagnosis, and possibly surgery or treatment involving body contact, with the request, either express or implied, that whatever is necessary to give relief be done, then the doctor is safe to assume that his acts are consented to and will only be answerable for his lack of proper knowledge, skill or care.²¹

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¹⁷ *Infra, circa*, nos. 100-127.
²¹ *Supra*, n. 15.
McGuire v. Rix\textsuperscript{22} the plaintiff patient was taken to the hospital where she requested that the defendant reduce a comminuted fracture of the astragalus of her right foot. She expressly consented to being anaesthesized, but not to an operation. While the patient was unconscious, the defendant found it necessary to operate and did so without delay. The court held that consent for the performance of the operation could be implied from the fact that the plaintiff had requested that the fracture be reduced and had consented to the administration of an anaesthetic. Similarly, in Dicenzo v. Berg,\textsuperscript{23} where the plaintiff had sustained fractures of certain vertebrae when struck in the head, it was held that consent to operate upon and above the neck in accordance with usual medical practice was implied, although the plaintiff while fully understanding the circumstances had expressly prohibited the making of an incision above the neck. Usually an express prohibition will fix liability upon a surgeon if he disregards it.\textsuperscript{24} However, in the Dicenzo case implied consent could be found because the patient had requested that necessary medical care be provided, and that which was provided was in accordance with customary medical practices. Thus, it seems relatively clear that, where a patient requests either by implication or expressly that remedial steps be taken, a physician will not be held liable for performing an operation which is generally accepted to be proper for the care of the specific ailment, unless he is negligent in performing the operation.

2. Consent to a Related Operation Sometimes Implies Consent

It has been found in a few cases that consent could be implied for the performance of an operation related to the one for which consent was specifically given, where it was impractical to attempt to gain consent and it was reasonably probable that consent would readily be given.\textsuperscript{25} In Delahunt v. Finton,\textsuperscript{26} the defendant, in making a diagnostic examination of the plaintiff with his consent, administered an anaesthetic and passed a filiform bougie through the urethral passage into the bladder. On attempting to remove the instrument it was discovered that it had

\textsuperscript{22} 118 Neb. 434, 225 N.W. 120 (1929).
\textsuperscript{23} 340 Pa. 305, 16 A. 2d 15 (1940).
\textsuperscript{24} Chambers v. Nottebaum, 96 So. 2d 716 (Fla. 1957); Bishop v. Shurly, 237 Mich. 76, 211 N.W. 75 (1926). See discussion infra, circa, ns. 33-36.
\textsuperscript{25} Supra, n. 19.
\textsuperscript{26} Supra, n. 19.
become hooked in the bladder, and the defendant immediately operated. The court held that the operation was necessary and that consent therefore was clearly implied. Of like import was *Higley v. Jeffrey*,27 wherein it was held that the defendant was not liable for reopening an incision to remove a needle, after performing a consented to operation in the course of which the needle had been misplaced. The court there clearly indicated that the second operation was closely related to the first and made necessary by the first, and therefore consent could be implied from that given for the first operation.

Exactly how closely related the law requires the two operations to be is far from clear. There is no question but that there was a close relationship in the two cases discussed above. However, in *Caron v. Gagnon*,28 wherein the patient consented to the performance of an appendectomy and the defendant surgeon also removed her ovaries which were diseased, the court implied consent for the removal of the ovaries from the fact that the patient had stated that she hoped she would never have to undergo another operation. It is clear that the surgeon could have closed his incision and later obtained consent to remove the patient's ovaries without endangering her life or health. Many courts would require that consent be obtained under such circumstances,29 but here the operation was in the same general region and the court felt that the patient would have given her consent. Perhaps the broadest view taken by any court is that expressed in *Bennan v. Parsonnet*.30 In that case the defendant surgeon while operating for a left hernia discovered a dangerous condition to exist on the right side as well and performed both operations. In finding that the second operation was consented to by implication the court said:

"The surgical employment of anaesthesia has, as matter of common knowledge, not only eliminated the possibility of obtaining the patient's consent during the operation, but has also had other radical effects of which notice must be taken. * * * The conclusion, therefore, to which we are led is that when a person has selected a surgeon to operate upon him, and has

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27 *Supra*, n. 19.
28 *Supra*, n. 19.
29 Beringer v. Lackner, 331 Ill. App. 591, 73 N.E. 2d 620 (1947); Rothe v. Hull, 352 Mo. 926, 180 S.W. 2d 7 (1944); Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913); Paulsen v. Gundersen, 218 Wls. 578, 260 N.W. 448 (1935).
30 83 N.J.L. 20, 83 A. 948 (1912).
appointed no other person to represent him during the period of unconsciousness that constitutes a part of such operation, the law will by implication constitute such surgeon the representative pro hac vice of his patient, and will, within the scope to which such implication applies, cast upon him the responsibility of so acting in the interest of his patient that the latter shall receive the full benefit of that professional judgment and skill to which he is legally entitled.

It is a rather unique and broad concept that the law should recognize the surgeon to be the representative pro hac vice of the patient, since in many instances other courts have indicated that a close relative could not provide the required consent unless the patient is, when conscious, mentally incapable of consenting. However, it is noted that in the above quote the court restricted the representative authority of the surgeon to the general scope of medical care for which the original operation was performed. In short there must be some relationship between the two operations.

3. Restriction and Exhaustion of Consent

If a patient gives consent and either expressly or impliedly places a restriction thereon or gives express instructions, such a restriction or instructions must be complied with, and an operation which is not performed in accordance therewith will be held to be tortious. In Rolater v. Strain the plaintiff had expressly prohibited the removal of any bones while the defendant operated to drain a puncture wound in her foot. The surgeon removed a sesamoid bone, and the court held that in so doing he had committed an actionable assault and battery. The underlying concept is that, where a physician agrees with his patient to use a designated anaesthetic or to perform a particular operation, he is bound to such agreement unless some unusual circumstance arises from which consent can be implied regardless of the prohibition. Further, a patient has a right to expressly prohibit surgery even if such is necessary to preserve his life, and if such prohibition

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*Id., 949-950.*

*Chambers v. Nottebaum, 96 So. 2d 716 (Fla. 1957); Bishop v. Shurly, 237 Mich. 76, 211 N.W. 75 (1926); Sullivan v. Montgomery, 155 Misc. 448, 279 N.Y.S. 575 (1935).*

*Supra, n. 29.*

*Bishop v. Shurly, supra, n. 32.*
is present the operation cannot be legally performed.\(^{35}\) In relation thereto the physician cannot be held liable for malpractice if he does not operate even though his failure to operate would be criticized in medical circles.\(^{36}\) It may be that such a prohibition is evidence of a diseased mind and is invalid, and at least arguably would not prevent surgery. A person who is non compos mentis is incapable of consenting and conversely should be incapable of refusing consent.\(^{37}\) Therefore, if there is imminent peril to the patient’s life, especially if self-inflicted, consent may be implied although expressly refused. It is also clear that consent cannot be refused if the operation is one compelled by law since the mandate of the law is directed to both physician and patient.\(^{38}\)

Exactly when a surgeon has surpassed the consent of the patient is not absolutely clear. However, it is possible to give the issue some clarity by an examination of the cases wherein it was found that consent had been exhausted. In *Rothe v. Hull*\(^{39}\) the plaintiff had employed the defendant surgeon to remove her appendix. On operating the defendant not only removed her appendix but also her Fallopian tubes. There was evidence that the defendant had given the plaintiff general authority to relieve her condition and further that while the operation was in progress the defendant advised the plaintiff’s husband of the condition of the tubes and he may have authorized their removal. Nonetheless, the court held that the evidence only revealed general authority with relation to the appendix and therefore by proceeding to remove the Fallopian tubes the defendant had committed a tort. Similarly, it has been held that consent was exceeded where a surgeon, in obtaining necessary facia to separate and cushion the deep tendons in the plaintiff’s hand, without gaining consent, removed facia from her thigh;\(^{40}\) where the defendant removed the plaintiff’s right testicle during an operation for the removal of a hernia in the right groin;\(^{41}\) where the defendant performed an ossiculectomy on plaintiff’s left ear

\(^{35}\) Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92, 93 (1914); Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913); Bishop v. Shurly, *supra*, n. 32 — agreement made by a surgeon is binding upon him.

\(^{36}\) Littlejohn v. Arboagast, 86 Ill. App. 505 (1901); Childers v. Frye, 201 N.C. 42, 158 S.E. 744 (1931).

\(^{37}\) Farber v. Olkon, 40 Cal. 2d 503, 254 P. 2d 520 (1953); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).


\(^{39}\) 352 Mo. 926, 180 S.W. 2d 7 (1944).


which he discovered to be diseased while supposedly operating on the right ear; and where the defendant removed a sesamoid bone in making an incision to drain a puncture wound against instructions. A similar result was seen where the defendant removed a fibroid tumor while the plaintiff was under anesthesia only for the purpose of allowing a thorough examination of the tumor, and where defendant operated for the purpose of performing a curettement, but instead performed a complete hysterectomy. Dentists have also been held liable where they removed two molar teeth instead of removing the patient's baby roots; and where they removed an impacted tooth while the patient was under anesthesia for general dental work.

The problem becomes more acute where a surgeon on performing a minor operation finds that the condition is more serious than he had anticipated. In Paulsen v. Gunnersen it was held that consent had been exceeded where the defendant after obtaining consent for a "simple" mastoid operation performed a "radical" mastoid operation. Similarly, it was held in Wall v. Brim that consent was exceeded when the surgeon after making his incision discovered that the operation would be more serious than anticipated, but proceeded anyhow.

From the above cases it can be seen that legal liability may arise although consent was initially given if a surgeon also operates in a different region of the body or upon a different organ of the body than anticipated, or if he proceeds with an operation which is more serious than the one for which consent was given. The basic idea is simply that, if the circumstances do not present imminent peril to life or limb the patient has a right to decide for himself whether he desires to have the operation performed, and if different circumstances are discovered while he is unconscious he has a right to know those circumstances since had he been aware of them he may have refused to give consent. It might reasonably be asked why consent could not be implied in the cases immediately above if

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42 Mohr v. Williams, 96 Minn. 261, 104 N.W. 12 (1905).
43 Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913).
44 Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914).
48 218 Wis. 578, 230 N.W. 448 (1935).
49 138 F. 2d 478 (5th Cir. 1943).
CONSENT TO OPERATION

it was implied in Caron v. Gagnon and Bennan v. Parsonnet. Some explanation lies in the fact that the jurisdictions wherein those cases were decided adopt a more liberal view than most. However, some distinction can be made in that the patient in the Caron case expressed a strong feeling that she hoped she would never have to undergo surgery again, and in the Bennan case there was a very close relation of symptoms between each hernia condition and in addition there was some question as to whether the right hernia did not present an emergency.

4. Doctrine of Emergency

As has been indicated above, if the circumstances of a given case present a danger to the life, limb or health of the patient and the surgeon is unable to obtain the consent of the patient before operating, either because he is unconscious, intoxicated, insane or otherwise legally incapable of consenting, consent will be implied. It is noted, however, that if the patient, although dying, refuses to consent, no consent will be implied. The primary problem relating to the emergency doctrine lies in attempting to give an adequate definition to what the law considers to be an emergency. How grave a danger must exist, and to what must it relate? Must there be a danger to the patient's life? If only a danger to the patient's health is required, what is the definition of "health" as used in this connection? Additional queries may arise as to when, in the stage of medical assistance, can the doctrine be invoked? Is it applicable only where an emergency is immediately detectable, or can it be invoked to extend an operation already in progress or to perform an unrelated operation which will remedy the situation which was unknown until the original operation had been commenced?

The emergency doctrine, as it has been most often stated by the courts, was enunciated in Mohr v. Williams in the following words:

"If a person should be injured to the extent of rendering him unconscious, and his injuries were of

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50 68 Quebec S.C. 155 (Quebec 1939).
51 83 N.J.L. 20, 83 A. 948 (1912).
53 Supra, n. 35.
54 95 Minn. 261, 104 N.W. 12 (1905).
such a nature as to require prompt surgical attention, a physician called to attend him would be justified in applying such medical or surgical treatment as might *reasonably be necessary for the preservation of his life or limb* ... \(^{55}\)

At first glance the standards set by the above doctrine would appear to be clear. However, as soon as one attempts to use it as a guide in practice the ambiguity of the test becomes readily apparent. What does "reasonably necessary" mean? Does "limb" only include the legs and arms, or will it be interpreted to include a digit? Since many courts have extended the rule so as to include life, limb and health, what does the term "health" include?

Although the doctrine is vague some clarity can be gained by examining the fact situations of certain cases. In *Mohr v. Williams*, supra, the defendant surgeon found a serious condition to exist in the plaintiff's left ear, while he was supposedly operating on the right ear. Although there was a good possibility that if an ossiculectomy was not performed on the left ear in the near future the plaintiff would have had her hearing seriously impaired, nonetheless the court could not find that the situation warranted the operation without first obtaining the patient's express consent.

On the other hand, in *Luka v. Lowrie*, \(^{56}\) the court had no difficulty in finding that an emergency existed where the plaintiff had suffered a compound disarticulation of the bones of his foot. It is noted that in that case the defendant was called in after four other physicians had examined the foot and agreed that surgery was necessary. Thus, it was clear that the operation was reasonably necessary. Similarly, an emergency has been found to have justified surgical treatment where the patient's leg was amputated after developing gas bacillus and gangrene, \(^{57}\) where the patient's arm was amputated and head treated after he was struck in the head while jumping from a freight car and was dragged a considerable distance; \(^{58}\) where the plaintiff, a child, was forcefully taken to the hospital against his wishes, after having had his foot run over by a train; \(^{59}\) and where chloroform from which the patient died was administered during an operation to reduce a fracture of

\(^{55}\) *Id.*, 15. Emphasis added.

\(^{56}\) 171 Mich. 122, 136 N.W. 1106 (1912).

\(^{57}\) Browning v. Hoffman, 90 W. Va. 568, 111 S.E. 492 (1922).

\(^{58}\) Jackovach v. Yocom, 212 Iowa 914, 237 N.W. 444 (1931).

his arm.\textsuperscript{60} However, it was held that no emergency existed where a surgeon felt it necessary to perform a tonsillectomy while allegedly performing an operation on the septum of the plaintiff's nose,\textsuperscript{61} where a surgeon removed the seriously diseased tonsils and adenoid of the plaintiff's child without consulting the plaintiff;\textsuperscript{62} where in performing an appendectomy, a spinal anaesthetic was administered contrary to the plaintiff's instructions after he had reacted badly to sodium pentothal;\textsuperscript{63} where a surgeon amputated the patient's leg which had been crushed and mangled.\textsuperscript{64} It is clear from the above cases that, if the emergency presents an imminent danger to the patient's life, the surgeon is justified in proceeding with an operation. However, it is not easy to deduce the minimum requirement. In this regard at least two views have been indicated. Some courts, probably in order to find the easiest answer to the question, have adopted the view that the situation must be such that death would likely result \textit{immediately} or upon failure to operate promptly.\textsuperscript{65} It is plain that this view is entirely too restrictive and would prevent diligent surgeons from attempting to obviate serious physical handicaps. Nonetheless, in \textit{Tabor v. Scobee},\textsuperscript{66} the Court of Appeals of Kentucky, in holding that no emergency existed sufficient to imply consent for the defendant to remove the diseased Fallopian tubes of the plaintiff while operating to remove her appendix, said:

"The evidence indicated that the removal of the tubes probably would be necessary soon, that their remaining in the body in their swollen and infected condition was dangerous, but it did not establish that their removal was an emergency in the sense that death would likely ensue \textit{immediately} if the tubes were not removed . . . . Although delay in their removal might have proved \textit{harmful}, even \textit{fatal}, there still was time to give the . . . patient the opportunity to weigh the fateful question."

\textsuperscript{60} \textit{Wells v. McGehee}, 39 So. 2d 196 (La. 1949).
\textsuperscript{61} \textit{Hively v. Higgs}, 120 Or. 588, 233 P. 363 (1927).
\textsuperscript{63} \textit{Chambers v. Nottebaum}, 96 So. 2d 716 (Fla. 1957).
\textsuperscript{64} \textit{Rogers v. Sells}, 178 Okla. 103, 61 P. 2d 1018 (1936).
\textsuperscript{65} \textit{Tabor v. Scobee}, 254 S.W. 2d 474 (Ky. 1951); \textit{Moss v. Rishworth}, 222 S.W. 225 (Tex. 1920). This view may be explained in that the patients were infants. See \textit{infra, circa}, ns. 113-118.
\textsuperscript{66} \textit{Id}.
\textsuperscript{67} \textit{Supra}, n. 65, 476-477. Emphasis added.
But, compare King v. Carney⁶⁸ wherein the Appellate Court of Oklahoma found that a surgeon acted justifiably in an emergency in removing both the ovaries and Fallopian tubes of the plaintiff during an operation to cure a laceration of her womb. The King case represents the more widely accepted view that an operation may be commenced or extended without first gaining express consent if conditions are such that they endanger the life or health of the patient. Under this theory there appears to be more discretion placed in the surgeon and he is allowed to more adequately perform his duties for the benefit of his patient. An excellent illustration of the workings of the emergency doctrine in a jurisdiction adopting the more liberal view is seen in the opinion of the Municipal Court of Appeals for the District of Columbia in Barnett v. Bachrach.⁶⁹ In that case the defendant had operated upon the plaintiff, a pregnant woman, to relieve a condition which had been diagnosed to be tubal or extra-uterine pregnancy, but having found her pregnancy to be normal proceeded to remove an inflamed appendix. The court, in holding that an emergency was present, analyzed the problem as follows:

"What was the surgeon to do? Should he have left her on the operating table, her abdomen exposed, and gone in search of her husband to obtain express authority to remove the appendix? Should he have closed the incision on the inflamed appendix and subjected the patient, pregnant as she was, to the danger of a general spread of the poison in her system, or to the alternative danger and shock of a second, independent operation to remove the appendix? Or should he have done what his professional judgment dictated and proceed to remove the offending organ, regarded as it is as a mere appendage serving no useful physiological function and causing only trouble, suffering, and oft times death.?⁷⁰

The court, thus recognized that probably there would not have resulted immediate death had the surgeon attempted to get consent, but stressed that there was danger to life and probably imminent danger to the patient's health, as well as possible loss of her child.⁷¹ The court took notice of the fact that pregnancy combined with appendicitis

⁶⁸ 85 Okla. 62, 204 P. 270, 26 A.L.R. 1032 (1922).
⁷⁰ Id., 627-28.
⁷¹ Supra, n. 69, 628.
often leads to abortion or miscarriage. Similarly the court in *Bennan v. Parsonnet* in designating the surgeon to be the representative of the patient in such circumstances said that “the law by its constructive power will raise up such a representative without which the welfare and even the life of the patient may be needlessly sacrificed.” Thus, it becomes reasonably clear that a surgeon may feel safe in operating or in extending an operation without having obtained express consent, if the condition of the patient presents an imminent danger to his life, limb or health, except in those jurisdictions which demand that the patient’s life be in immediate peril.

**FACTORS PREVENTING CONSENT**

There are various factors which may prevent effective consent. Although consent may be expressly given, for one reason or another it may not be valid. Generally speaking consent may be vitiates by fraud, coercion, mistake or because the patient is incapable of consenting because he is a minor, intoxicated or non compos mentis.

1. *Fraud*

It is reasonably clear in the law that if consent for the performance of an operation is obtained through fraud such consent is invalid. Such fraud may be through a misrepresentation of the character of an operation, or through a misrepresentation of the usual or expected results thereof. In *Hobbs v. Kizer* it was found that the plaintiff’s consent was vitiates by fraud where she had consented to an operation for the supposed removal of a vaginal abscess and the defendant surgeon all the time intended to perform an abortion which he had made necessary by having had

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“If the plaintiff manifests consent to the defendant’s act under a mistake as to its nature or character, the consent will still be effective, unless the defendant is aware of the mistake, or has misrepresented the nature of his act.”

It is noted that all that may be necessary to constitute fraud in these cases is that an advantage be taken of the plaintiff’s ignorance in order to perform an operation for which he may not have consented.
74 Hobbs v. Kizer, 236 F. 681 (8th Cir. 1916).
75 Kinney v. Lockwood Clinic Ltd., supra, n. 73.
76 *Supra*, n. 74.
illicit relations with her. In England a similar result was reached in Regina v. Case\textsuperscript{77} where a physician, while purportedly treating a fourteen year old girl for suppressed menstruation, had sexual intercourse with her under the guise of providing proper medical treatment. Thus, it is clear that operating or supposedly rendering treatment in accordance with consent which was obtained by a concealment of the true nature of the act, is tortious.

In a like manner one will be liable, if he operates or renders treatment without properly enlightening the patient as to the usual or expected results thereof. In Kinney v. Lockwood Clinic, Ltd.\textsuperscript{78} the Supreme Court of Ontario held that the consent given by a patient who had submitted to an operation for Dupuytren's contraction was vitiated because the defendant surgeon had not advised the patient that the operation entailed considerable risk, and even though successful might produce a more aggravated condition.

The question of fraud, as can be seen from the above cases, has particular significance where a doctor intends to perform a graver operation than the patient thinks when he consents. Thus, in State v. Housekeeper\textsuperscript{79} the Court of Appeals of Maryland, in talking of voluntary submission to surgery, said:

"... if [a patient] voluntarily submit[s] [to a dangerous surgical operation], her consent will be presumed, unless she was the victim of a false and fraudulent misrepresentation, which is a material fact to be established by proof."

\textsuperscript{80}

2. Coercion

The law will not recognize consent, if it was given as a result of coercive measures.\textsuperscript{81} One cannot by means of threats, intimidation or force compel another to undergo surgery. In Meek v. City of Loveland\textsuperscript{82} the plaintiff, after being mistakenly shot by a policeman, was taken to a city

\textsuperscript{77} Supra, n. 78.
\textsuperscript{78} Supra, n. 75.
\textsuperscript{79} 70 Md. 162, 16 A. 382 (1889).
\textsuperscript{80} Id., 170. It is noted that, if the fraud were perpetrated in obtaining the permission of the parents or guardian of a person incapable of consenting, the consent would also be invalid.
\textsuperscript{81} Meek v. City of Loveland, 85 Colo. 346, 276 P. 30 (1929). Where consent is obtained through coercion or duress, it is considered that there was no consent at all, since in fact the patient submits himself to the defendant's act against his desires.
\textsuperscript{82} Id.
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physician and over objection removed to an institution wherein an operation was performed. The plaintiff had constantly expressed a desire to consult his own physician. The court held that the city physician, the surgeon and the chief of police who had taken the plaintiff to the hospital were liable. But compare Ollet v. Pittsburg, C.C. & St. L. Ry. Co. wherein the crew of a railroad train which had run over a boy crushing his foot took him to a hospital over his protests. It was there held that no action would lie for false imprisonment. Although appearing to be irreconcilable, the Ollet case is distinguishable from the Meek case on the grounds that the patient was a minor and incapable of giving his consent, and an emergency there existed which made it highly impractical to wait until the boy's parents could be notified.

3. Mistake

If a physician or surgeon through his own mistake renders treatment or operates upon the wrong person or in a manner which was contrary to the understanding between the parties, the submission of the person to such care will not create implied consent. The law will not imply consent for acts of medical treatment which neither party, physician or patient, had contemplated. Thus, in Hershey v. Peake it was held that the patient might recover for malpractice where the defendant, a dentist, was authorized to extract certain teeth but by mistake extracted the wrong ones. Similarly, it has been held that consent was lacking where a patient on returning to her physician's office merely to obtain the results of a blood test, was given a lumbar puncture meant for another; and where an eye specialist unnecessarily opened and cleaned out the right antrum of the patient without obtaining his consent, while believing him to be another patient. These cases are

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82 201 Pa. 361, 50 A. 1011 (1902).
83 See discussion infra, infra, ns. 100-115. It is clear that coercion makes little difference in relation to a patient who is incapable of consenting, since even in absence of force or duress the consent would be invalid. However, the problem could easily arise in cases dealing with such persons, if by means of duress the patient's parent or guardian was compelled to consent. In such an instance the consent would again be vitiated.
84 Hershey v. Peake, 115 Kan. 562, 223 P. 1113 (1924); Sullivan v. McGraw, 118 Mich. 39, 76 N.W. 149 (1898); Gill v. Selling, 125 Or. 587, 267 P. 812 (1928); Samuelson v. Taylor, 160, Wash. 369, 295 P. 113 (1931). In actuality the law indicates that an operation contrary to the understanding of the parties, regardless of what the reason is, constitutes a breach of contract as well as a tort.
85 Id.
86 Gill v. Selling, supra, n. 85.
87 Samuelson v. Taylor, supra, n. 85.
closely akin to those involving an unwarranted extension of an operation or the performance of an operation which bears no relation to that for which consent was given. However, here the element of intent is considerably weaker, if not lacking altogether. It is reasonable to say that the defendant would not have operated or would have performed the proper operation had he not been confused. For this reason the courts have been reluctant to grant any punitive damages in such cases.\(^8\)

4. Illegal Operations

There is a split of authority as to whether one can consent to an unlawful operation. In many jurisdictions it has been held that the consent of the plaintiff will not avail as a defense in a civil suit for damages for injuries arising out of an illegal operation.\(^8\) Thus, in *Joy v. Brown*\(^8\) it was held that the next of kin of the patient, who had submitted and consented to the performance of an abortion which was not necessary for the preservation of life, could recover from the surgeon on the theory that "... no person may lawfully and validly consent to any act the very purpose of which is to destroy human life."\(^9\) The general theory behind the cases taking this position is that the operation is a matter in which the state has an interest, and since it transgresses the public peace, no person can validly consent to such an act. Similarly in *Miller v. Bayer*\(^9\) it was held that the patient upon whom an abortion had been performed could recover from both the surgeon and the paramour who had been charged with rape.

On the other hand, there are many jurisdictions which have adopted a more modern view, which states that consent to an immoral or illegal act constitutes a bar to recovery of damages for injury resulting therefrom.\(^9\) In short the legal axiom *volenti non fit injuria* applies. Thus

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\(^8\) Gill v. Selling, *supra*, n. 85; Samuelson v. Taylor, *supra*, n. 85. It is clear that the doctrines discussed above are applicable in cases involving persons incapable of consenting. However, there is some doubt as to whether the courts would grant punitive damages, especially if the parent or guardian of the patient was present.


\(^9\) *Id.*


\(^9\) *Supra*, n. 90.

in *Miller v. Bennett*\(^6\) it was held that the administrator of the estate of a patient who had consented to being aborted could not recover since the deceased was guilty of moral turpitude and she, had she lived, could not have recovered. Following the same line of reasoning it was held in *Sayadoff v. Warda*\(^6\) that the paramour who had arranged and financed the abortion could not be held liable since the patient had expressly consented thereto.

Although the division of cases is rather distinctly drawn, it would clearly appear that the modern trend is to recognize the patient’s consent to be a bar and thereby apply the maxim *volenti non fit injuria*. The weight of reason is clearly behind this position, since, if a court is to allow a recovery for submission to the commission of a crime, it is in effect rewarding the person at whose request the crime was committed. It is noted that if an emergency exists which demands the performance of an abortion or other operation, it is not an illegal operation and the consent of the patient will be effective under either view, or it may be raised by implication, as in any other case. However, if the operation is absolutely necessary but the patient refuses consent, an action will probably lie if such an operation is performed. It may be queried as to what will constitute an emergency in cases of this nature. This question is usually controlled by state statutes. Under most, it would clearly appear that there must be an imminent danger to the life of the expectant mother or the fetus must already be dead. If a state accepts the first view discussed above, a doctor who performs such an operation may be prosecuted both civilly and criminally and thus held doubly liable. If a state accepts the second view, the doctor is still subject to criminal prosecution. In either event the results are extremely undesirable.

**INCAPACITIES**

The most complex problems relating to consent to operative procedures arise where the patient demonstrates some incapacity which will prevent his purported consent from having any meaning. One may be legally incapable of consenting if he is a minor,\(^97\) non compos mentis,\(^98\) or otherwise unable to understand the nature and significance

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\(^6\) 190 Va. 162, 56 S.E. 2d 217 (1949).
\(^6\) Supra, n. 94.
\(^6\) Farber v. Olkon, 40 Cal. 2d 503, 254 P. 2d 520 (1958); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).
of the situation. At common law a married woman was also legally incapable of entering into a binding contract, and similarly she was incapable of consenting to an operation. Wisely, the law has recognized that a married woman is as capable of determining what shall be done with her body as an unmarried woman or a man. Therefore, unless there are symptoms of some other incapacity, one may rely on the consent of a married woman.

As indicated above the bases for legal incapacity to consent are essentially the same as those given for entering into a contractual relationship. To be able to consent the patient must be able to comprehend the seriousness of his condition, the nature of the proposed treatment or operation, the expected results, and possible consequences thereof. If he does not have sufficient grasp of his mental faculties so as to understand the situation when explained in simple terms, it cannot be said that he has consented. The theory is simply that one cannot consent to something of which he is rationally unaware. There is actually very little theoretical difference between the reasons why fraud vitiates consent, and incapacity prevents the giving of consent altogether. In the first case, as seen earlier, consent is vitiates because the character of the patient’s condition or the nature of the operation is misrepresented. Thus, through the representations of the physician, the patient is prevented from being aware of the true nature of the medical care to which he has submitted himself. In the case of persons who lack capacity the same reason is applicable. The only difference is, that his comprehension of the situation is prevented by some factor personal to himself rather than a deliberate withholding of information by another.

1. Minority

Due to the general lack of knowledge, experience and reasoning power of minors, the law has made provisions for their protection. In relation to the power of a minor to consent to operative procedures, there is a tendency for the courts to look more toward the intellectual maturity of the patient than toward his age. It is clear that if the
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patient has attained his majority the courts will give recognition to his consent. However, it is not always necessary that he have attained the age of majority. In Gulf & S. I. R. Co. v. Sullivan" it was held that the patient, an infant of seventeen years, was capable of consenting to being vaccinated since the patient understood and appreciated the purpose for, and consequences of the vaccination. It has been held also that the consent of the nineteen year old infant patient was sufficient where he had consented to the use of propane after the plaintiff parent had expressly prohibited its use; and, where a twenty year old boy was anaesthesized for the purpose of setting a broken ankle and placing a cast thereon. It is important to note that in the first case the parent had actually refused consent, which would have been an absolute bar to the use of propane, had the minor been unable to give consent himself. However, although the parents were still legally responsible for the care of the child, it still being a minor and unemancipated, the consent of the child was given recognition and not the refusal thereof by the parent.

In each of the instances mentioned above the operation involved was relatively minor in nature and was considered to be within the comprehension of the patient. The converse was true in Tabor v. Scobee wherein it was held that the plaintiff, an infant of twenty years at the time of the operation, could recover from the surgeon for the removal of her Fallopian tubes during the performance of an appendectomy, since he had failed to obtain permission to remove the tubes from the plaintiff's stepmother and guardian. Here, of course, the operation was much more serious and although the patient was twenty years old she probably could not have understood the full significance of the operation. Therefore, it was the lack of her guardian's consent which gave rise to liability. Similar results have been reached where an operation for the removal of the tonsils of an eleven year old boy was performed without the consent of his parents; where an operation was performed on a fourteen year old boy for the amputation of his foot in absence of the consent of his parents; and where, without consent, an infant's

101 Ibid.
104 254 S.W. 2d 474 (Ky. 1951).
105 Moss v. Rishworth, 222 S.W. 225 (Tex. 1920).
tonsils and adenoids were removed. Thus it becomes clear that if an operation is reasonably serious, consent must be obtained from the minor's parent or one in a position of loco parentis with him, but if the operation is very minor the consent of the minor may be sufficient. The factors to be considered in determining whether an infant is intellectually mature enough to comprehend the nature of his condition and the steps to be undertaken to remedy it depend to a large extent upon the seriousness and complexity of the operation. Regardless of the fact that the child may be capable of consenting, it would be wise in every case to obtain parental consent in addition to the consent of the minor, since it is never certain that he does understand the situation, and even if a surgeon is sure that he does, a judge or jury may not agree.

The reader may query as to the applicability to the emergency doctrine to cases involving infants. It is clear that, if there is an impending danger to life or limb which must be acted upon without delay, consent will be implied. However, if the danger is not so imminent, it appears that some effort must be made to obtain the consent of one standing in loco parentis with the patient. This problem was thoroughly dealt with in Browning v. Hoffman wherein the plaintiff had suffered a broken leg. The leg was reduced and dressed and the patient retained in the hospital. Complications arose in the form of gas bacillus producing gangrene and amputation became necessary. The amputation was duly performed without obtaining the consent of the patient's father, and while the mother was objecting — she demanding that the father be consulted. The court held that no action would lie since an emergency situation was present and the father, being a railroad employee, was practically unreachable. In so holding the court said that the law imposed no duty to find the parents and obtain their consent beyond a reasonable and diligent effort to do so. In comparison, it was held in Rogers v. Sells that the surgeon was not justified in


109 Moss v. Rishworth, id., Tabor v. Scobee, id., Cf., Sullivan v. Montgomery, id., which only required danger to life or health, or that suffering or pain may be alleviated.

110 90 W. Va. 568, 111 S.E. 492 (1922).

111 178 Okla. 103, 61 P. 2d 1018 (1936).
operating on the grounds of an emergency since the emergency must be such that it precludes any delay. If, therefore, any delay can be taken so as to make a reasonable effort to notify the parents or guardian of the patient, such effort to notify must be made. This principle was made clear by the Kentucky Court of Appeals in *Tabor v. Scobee.* The Court there said:

"But the law rightfully requires the consent of the patient or one in loco parentis whenever it is possible to obtain it in time. * * * The evidence indicated that [the operation] would be necessary soon, . . ., but it did not establish that [there] was an emergency in the sense that death would likely ensue immediately . . . ."\(^{113}\)

It would therefore appear that with regard to infants the emergency doctrine is given a stricter interpretation, and rightly so, since there is usually someone available who can consent.

The question may arise as to whether, in the event of an emergency, a surgeon may proceed to operate if the parent refuses. It must be remembered that an adult patient of sound mind may object to an operation even if death will follow, and in that case consent will not be implied from the circumstances. Thus, the situation may arise wherein a parent refuses to grant the necessary consent for an operation to be performed on the child. This problem was presented in the *Browning* case\(^ {113a}\) wherein the mother objected, desiring that her husband be notified. Nonetheless, the court held that there was an emergency and the surgeon was justified in proceeding. However, in that case the court implied consent from a combination of an existing emergency and a reasonable effort to reach the father. Thus, it does not squarely answer the question as to what result will be reached if both parents, or the father rather than the mother refuses. This problem possibly can be answered by analogy from certain doctrines discussed in the recent Maryland case of *Craig v. State*\(^ {114}\) wherein it was indicated that parents who demonstrate a wanton and reckless disregard for the welfare of their children can be held criminally liable. Since the refusal to consent may be criminal it is arguable that this refusal of the parent

\(^{112}\) Supra, n. 108.
\(^{113}\) Supra, n. 108, 476. Emphasis added.
\(^{113a}\) Supra, n. 108.
\(^{114}\) 220 Md. 590, 155 A. 2d 684 (1959).
would not be binding on a surgeon where the operation is imminently necessary for the preservation of the child's life. The theory would be that the parent by his criminal act has made himself unavailable to consent and therefore consent could not be obtained through a reasonable effort.\textsuperscript{116}

From the above it is clear that, if an infant is not intellectually matured to a point at which he can understand his physical condition and the nature and possible consequences of the proposed treatment or operation, the consent of the parents or guardian must be obtained, unless there is an emergency such that impending danger to the infant's life is present.

2. Intoxicated Patients and Patients Non Compos Mentis

It is equally clear that consent by a person who is either intoxicated or non compos mentis is invalid.\textsuperscript{116} These two incapacities will be discussed together since the problems are essentially the same although less numerous where intoxicated persons are involved. The problem at the outset is in determining when a person is non compos mentis for the purpose of giving consent. Is it necessary that he be a danger to himself, other persons or property, as is required in many jurisdictions in order to have him committed to a mental hospital by means of legal process, or is some other test to be applied? Although this question has not been directly answered by the courts, it would be logical to surmise that since incompetency for other purposes is based upon whether or not the patient is able to comprehend the nature of his condition, a lacking of this ability as a result of mental disease or alcohol or drugs is all that is necessary. There are many persons who do not constitute a danger to themselves, society or property, and yet are unable to comprehend their physical condition or the nature of an operation. On the other hand, the converse is also true. Therefore, it would be illogical to use the same test to determine mental capacity for commitment purposes for determining capacity to consent. The standard should be one of understanding and comprehension more analogous to the tests of sanity used to determine the validity of a will or contract — does the patient under-

\textsuperscript{116} It is noted that in order to fix criminal liability on the parent, the court must recognize that a refusal was in fact made. However, because the law would recognize that there was a refusal, this does not necessarily mean that it would be binding on the surgeon. It would be inconsistent to say that a particular act is illegal and yet legally binding on a surgeon.

\textsuperscript{116} Farber v. Olkon, 40 Cal. 2d 503, 254 P. 2d 520 (1953) ; Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).
stand the nature of a will or agreement, the dispositions or obligations made thereunder, the nature of the property being distributed or the nature of the actions to be taken, and the natural objects of his bounty or his natural personal interests.\textsuperscript{117} Such is clearly the general form of mental test to be applied in determining one's competency to consent. The standard is one of understanding and comprehension. However, if a patient has been declared legally insane it is reasonably certain that no validity can be given to his consent, and such must be obtained from his legal representative which is usually a person or committee appointed by the court.

In \textit{Farber v. Olkon}\textsuperscript{118} the question was presented as to whether parental consent alone was effective. In that case the patient, who had been mentally ill since the age of nineteen, brought suit by his guardian \textit{ad litem} to recover for fractures of his femur bones which resulted from shock treatment being rendered with the consent of his father. The court held that the father had a legal duty to care for the son under the California Welfare and Institutions Code\textsuperscript{119} and that the right to consent was in the father, and therefore, since he had given his consent, no liability could be affixed to the doctor who had administered the shock treatment. In so holding the court said:

"We are of the view that where an adult child is incompetent and has no legally appointed guardian the right to consent to such treatment resides in the parent who has the legal responsibility to maintain such child."\textsuperscript{1120}

Similarly, in \textit{Pratt v. Davis}\textsuperscript{121} it was held that an action would lie against a surgeon who removed the ovaries and uterus of a mentally ill patient without the consent of her husband. Thus, it is clear that if the patient is mentally incompetent, the law requires that consent be obtained from the person legally responsible for the patient's maintenance and care.

The cases indicate that the doctrine of emergency applies to persons who are non composit mentis in the same

\begin{itemize}
\item Doyle \textit{v. Rody}, 180 Md. 471, 25 A. 2d 457 (1942);
\item Jones \textit{v. Collins}, 94 Md. 403, 51 A. 368 (1902);
\item Appeal of Macveagh, 141 Me. 260, 42 A. 2d 903 (1945).
\item Supra, n. 116.
\item CAL. WELFARE \& INSTITUTIONS CODE (1956) §§ 151.5, 154, 5700 \textit{et seq.},
\item 6726, 6559; CAL. CIVIL CODE (1954) § 206.
\item Supra, n. 116, 524.
\item 224 Ill. 300, 79 N.E. 562 (1906).
\end{itemize}
manner as it applies to persons otherwise incapacitated. In the Farber case the court, in drawing an analogy to the case of persons incapacitated because still in their minority, commented:

"In case of an emergency a surgeon may operate on a [minor] child without waiting for authority from the parents . . . where it appears impractical to secure it, but that in the absence of an emergency the parent of such a child may lawfully consent to the operation."

Therefore, the test to be applied in determining the applicability of the emergency doctrine is that relating to infants, and not that of normal persons. Following that concept it is necessary that the emergency present an actual threat to the life of the patient before consent can be implied. In relation to intoxicated or drugged patients, the emergency doctrine, as applied to those who are non compos mentis, would logically apply. However, here the question is not whether the surgeon can afford to delay long enough to obtain the consent of the patient's legal representative, but whether he can delay long enough for the effect of the alcohol or narcotic to wear off. It is probable that only in the case of an emergency can a surgeon feel safe in operating on an intoxicated or drugged patient, since otherwise it is not unreasonable to demand that he delay until the consent of the patient can be obtained, provided, of course, that the patient has reached his majority. It is noted that in many cases an alcohol or drug addict may be mentally ill as well as under the influence of an agent which numbs his senses. In such cases it would be wise to treat him as being non compos mentis, and obtain the consent of his legal representative or family as well as his consent, unless imminent peril of life is present.

An emergency operation appears to be justified under the normal test for the use of that doctrine if the patient when brought to the hospital is unconscious, in need of an operation to preserve life, limb or health, and is later found to be non compos mentis. Unless there are present clear symptoms or evidence that the patient is non compos mentis or otherwise incapacitated, a surgeon may feel reasonably safe in operating, if the situation constitutes an emergency under the rule applicable to normal, adult persons. Although this question has not arisen to date, it

122 Supra, n. 116, 524, partially quoting from 70 C.J.S., Physicians and Surgeons, § 48, p. 968.
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is logical that the law only require that the surgeon act reasonably. He cannot be expected to diagnose the mental condition of the patient without being able to talk with him or someone who has personal knowledge of his personality and habits. It would, therefore, seems logical that such an operation may be performed so long as a reasonable practitioner or surgeon would not be put on notice of mental disease.

If, in the absence of an emergency situation, the patient voluntarily submits to treatment or requests treatment, but shows signs of being non compos mentis his consent is probably invalid. It seems reasonable that if, after talking with the patient and considering the circumstances in which medical aid was sought, the physician should reasonably conclude that the patient does not comprehend what he is requesting or to what he is submitting himself, consent will not be implied. It is clear that, if a minor child so submits himself to or requests medical care, the physician will be held liable unless he is certain that the child can comprehend the nature of his condition and of the remedial measures to be taken. By analogy it would follow that the physician must make the same determination with regard to mentally ill persons. However, there is less likelihood that one who is not seriously mentally ill, and yet lacking comprehension, will be noticed, since the age of an individual is a more tangible thing to detect; and at the outset, it will act to place a physician on notice of possible incompetency. Nonetheless, care must be taken in each case to ascertain the mental condition of the patient for otherwise there is a definite possibility of being liable for such medical care as is rendered. The test is simply whether a reasonable physician would be put on notice of the incapacity. It might be queried as to whether there would be liability, if after treatment is rendered or an operation is completed, it is discovered that the patient was mentally defective. In such a case it seems logical that the surgeon would not be liable unless prior to operating he should have detected the mental condition. It is noted that in the case of drugged or intoxicated persons the theories discussed in relation to the preceding two problems apply, since there is no emergency and it would not be too inconvenient to delay until the person has regained his mental faculties and then obtain his consent.

From whom should the physician obtain consent if the patient is non compos mentis? The answer to this question is rather complex and requires the asking of several others. Assuming that the patient has a family and is either not committed to a mental hospital or is committed upon two doctor’s certificates, from whom should consent be obtained? It is clear in this instance that consent should be obtained from the family, as in the case of an infant. The particular member of the family would depend upon who is responsible or who has assumed the responsibility for the care and maintenance of the patient. As in the case of infants the law places a duty on such persons to make all decisions of this nature for the incompetent person. Thus a spouse should answer for the other spouse, a parent — preferably the father — for an unmarried person who has been incompetent since youth, a son or daughter for his or her parent where the son or daughter has assumed the responsibility for the care of the parent, or any other relative or non-relative who has been providing for the support of the patient. Suppose, however, that the patient has been married and divorced and has no other family, must the divorced husband give his consent? If there are children of a responsible age who have assumed the care of the patient, there is no need to try to locate the husband. But, if there are no children, the consent of the husband, who is obligated to support the patient by alimony payments, is probably necessary unless it would be futile to attempt to obtain it. Where the patient and the husband have been absolutely divorced, a vinculo matrimonii, it is doubtful that the mere obligation to provide alimony payments is a legal duty to provide care and support sufficient to make it necessary to obtain his consent to perform an operation of the non compos wife. However, where the divorce was merely a divorce a mensa et thoro, a legal separation, there may well be a sufficient duty. In any case it would be wise to seek to have the patient declared mentally incompetent by a court before operative procedures are undertaken. Consent
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would then be given by a committee appointed by the court to represent the patient.

Where the converse of the above situation is present — the husband is the one who is incompetent — it would probably be necessary to have him declared mentally incompetent by a court, unless there can be found some relative or friend who has assumed the care and maintenance of the patient. In this case it cannot be argued that the wife is obliged to care for her divorced husband on the basis of an alimony decree. However, there may be some basis for requiring her consent if she or he has only obtained a legal separation. Whether or not such an obligation can be imposed has not been decided by the courts, but regardless of the fact that an obligation could possibly exist, a physician will be protected if consent is obtained through legal process.

Assuming that the patient enters a mental hospital on a voluntary petition and possesses no family or person who has assumed responsibility for his care, from whom must consent be obtained if treatment or operative procedures are needed? If the patient has demonstrated his understanding of his condition sufficiently to realize that psychiatric help is necessary, it may be that he will understand a need for special treatment or for an operation. In that case his consent will probably suffice. But, suppose that after admittance the patient has deteriorated mentally so that he is no longer capable of understanding the nature of either his physical or mental condition, is his consent then valid? In such a case it would be necessary for the hospital to petition a court to declare the patient mentally incompetent and to appoint a committee. Consent would thereafter be obtained from the committee. It is noted that many administrative heads of psychiatric hospitals often assume the responsibility in these circumstances, but, legally speaking, they are guilty of a tort even if they do not perform the operation themselves, since they set in motion the means through which the operation was performed.

Finally, where a patient has been committed to a mental hospital by court order and needs either surgery or treatment a committee is generally appointed to act on his behalf, and it is from this committee that consent must be obtained. However, the situation may arise wherein the committee has conflicting opinions with the patient’s family. In this event it is reasonably clear that the committee is the legal representative of the patient and if it
is in disagreement with members of the patient's family; it will be the committee's decision which will be binding. Thus, in absence of an emergency which presents imminent peril to life, when dealing with persons who are non compositos mentis or otherwise incapacitated, the physician must determine who possesses a legal duty to maintain and care for the patient, and obtain consent from him before he can be safe in rendering treatment or in operating.

CONCLUSION

General Rule: Before an operation may be performed, or treatment rendered, it is necessary for a surgeon or physician to obtain the consent of his patient, if he is mentally capable of giving it, or if not, of his guardian, unless the circumstances are such that they demand immediate attention for the preservation of his life, limb or health. Where an operation is required by law there is no necessity to obtain consent since such is provided by the statute which makes the operation mandatory. In other cases consent may be express, implied in fact, or implied in law. Express consent may be either written or oral, and in either case be just as effective, except that should litigation arise the existence of the latter will be more difficult to prove. Implied consent may arise in many circumstances, the most common being where there is a request for medical assistance, or consent to a related operation, or consent to a more serious operation, or where an emergency is present. It is important to recognize that with regard to emergencies there are probably two tests to determine if one actually exists: (1) does the condition of the patient present an imminent danger to life, limb or health; and (2) with regard to minors and other persons incapable of consenting, is there such a danger to the patient's life that a reasonable effort to locate his parent or guardian in order to obtain consent cannot be made? Finally, it must be borne in mind that if consent is obtained through fraud, coercion or mistake it will be vitiated; and if the operation to be performed is illegal, consent thereto will have no effect in some jurisdictions, while in others it will constitute an estoppel and prevent the patient or his estate from recovering in an action at law.