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Surgery by an Unauthorized Surgeon as a Battery

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SURGERY BY AN UNAUTHORIZED SURGEON AS A BATTERY

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A patient awakes from anesthesia to learn that the surgery was a success. She is relieved until she learns that she was operated upon by a surgeon she had never heard of.

This is a case of "ghost surgery," surgery by a surgeon that the patient has not consented to.[2] Ghost surgery is a ground for disciplinary action.[3] The patient also has a cause of action for the emotional distress inflicted by the substitution.[4] But should she also have a cause of action for battery, which would allow recovery even for the normal and foreseeable effects of the surgery? If the patient has not been injured in an informed consent action, no

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[2]A typical ghost surgery case was Vitali v. Bartell, No. 353 206 (Cal. Super. Ct. Orange County Mar. 2, 1984), noted in Michael Rustad & Thomas Koenig, *Reconceptualizing Punitive Damages in Medical Malpractice: Targeting Amoral Corporations, Not "Moral Monsters,"* 47 RUTGERS L. REV. 975, 1033 n. 193 (1995). The plaintiff was scheduled for breast reduction mammoplasty by a board certified cosmetic surgeon. A less qualified surgeon who worked in his clinic substituted for him in the operating room without the patient's consent. *Id.*

[3]*See infra* note 24 and Appendix.

[4]*See* discussion *infra* notes 27-32 and accompanying text.

liability will result. But for battery cases, the plaintiff does not have to have been injured as a result of the defendant's conduct: The fact that a battery has occurred is sufficient.[5] Nor does it matter that the surgeon who performed the surgery is more experienced than the one to whom she consented.

This article examines the policy issues behind the doctrine of informed consent and reviews the decisional law and policies on the topic of ghost surgery. Jury instructions employed in California[6] are also addressed. The author concludes that substitution of surgeons should not automatically prompt liability for a battery. The public policy behind the informed consent doctrine is to favor patients' self-determination over the doctor's paternalism. Imposition of liability for battery in a case where the defendant does not knowingly deviate from the consent is not necessary to effectuate this purpose.

I. BATTERY AND CONSENT

Assault and battery are not defined in the California Civil Code. In tort actions for assault and battery, courts usually assume that the Penal Code and criminal cases are applicable.[7] The Penal Code definition of assault is "an unlawful attempt, coupled with a present ability, to commit a violent injury on the person of another."[8] Battery, according to the California Penal Code, is "any wilful and unlawful use of force or violence upon the person of another."[9]

While providing no definition of battery, the Civil Code does codify the maxim "volenti non fit injuria:" "He who consents to an act is not wronged by it."[10] Consent is generally a complete defense to tort liability.[11] But the

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[5]The distinction between cases based on battery and those resting on negligence due to an absence of informed consent has other important legal implications. In battery actions the statute of limitations is likely to be shorter. Punitive damages are more likely to be available in battery actions even where the actual damages are small. Expert testimony as to whether the physician breached his duty is not required in a battery action. Jesse A. Goldner, *An Overview of Legal Controls on Human Experimentation and the Regulatory Implications of Taking Professor Katz Seriously*, 38 ST. LOUIS L.J. 63, n. 68 (1993). The consequences of choice of theory of battery or negligence are also discussed in Note, *Informed Consent in Medical Malpractice*, 55 CAL. L. REV. 1396, 1399-01 and n.18 (1967). *See generally* Comment, *The Due Process of Dying*, 79 CAL. L. REV. 1121 (1991). For an analysis comparing the battery with the negligence aspects of a claim for failure to obtain consent to medical treatment, see GILBERT SHARPE & GLENN SAWYER, DOCTORS AND THE LAW 31-38 (1978).

[6]While this article focusses on California law, the law in other jurisdictions is likely to be similar or identical.

[7]BERNARD WITKIN, SUMMARY OF CAL. LAW, TORTS § 346 (9th ed. 1995); *see* Fraguglia v. Sala, 62 P.2d 783 (Cal. App. 1936); BOOK OF APPROVED JURY INSTRUCTIONS [BAJI], No. 7.51 (7th ed. 1991).

[8]Cal. Pen. Code § 240 (West 1992).

[9]Cal. Pen. Code § 242 (West 1992).

[10]Cal. Civ. Code § 3515 (West 1990).

[11]WITKIN, *supra* note 7, § 271 and authorities cited. The notion of informed consent

physician's good intentions are no defense if the procedure is found to be unconsented and the physician nonetheless proceeds.[12]

II. DEVELOPMENT OF THE DOCTRINE OF "INFORMED CONSENT"

Judicial development of the legal doctrine of informed consent initially was tied to the tort of battery, which is a non-consensual, intentional touching. Battery developed out of a basic judicial regard for the principle of individual autonomy, reflecting the belief that the individual "has the right to be free from non-consensual interference with his or her person."[13] Like the reasoning in a criminal battery setting, courts readily distinguished tortious from non-tortious surgery by observing that, in typical cases, the surgeon had the patient's consent to non-tortious surgery.

A. Schloendorff v. Society of New York Hospital: Patient's Right of Self-Determination

The notion of consent was placed in the medical context in *Schloendorff v. Society of New York Hospital*.[14] In *Schloendorff*, Justice Cardozo wrote:

> 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, for which he is liable for damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.[15]

While Justice Cardozo's reverberating words are quoted as grounds for the doctrine of informed consent, the case actually involved a physician who removed a fibroid tumor against his patient's explicit insistence that there be no operation.[16] Indeed, "the doctrine of consent was largely restricted to cases involving unauthorized surgery. This extension of surgery beyond what was

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may well have first been posed in a malpractice context in California in 1957 in Salgo v. Leland Stanford Jr. University Board of Trustees, where the court approved an instruction positing the existence of a duty to disclose. 317 P.2d 170, 181 (Cal. App. 1957). The earliest reported case dealing with consent to medical treatment is believed to be Slater v. Baker & Stapleton, 95 Eng. Rep. 860 (K.B. 1767), in which the patient prevailed on a negligence theory because the physician failed to adhere to the customary practice of obtaining consent before medical treatment. Frances H. Miller, *Denial of Health Care and Informed Consent in English and American Law*, 18 AM. J. L. & MED. 37, 61 n.134 (1992).

[12] W. PAGE KEETON, ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 119 (5th ed. 1984).

[13] JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 48-84 (1984).

[14] 105 N.E. 92, 93 (N.Y. 1914).

[15] *Id.* at 93.

[16] *Id.* at 92.

authorized, or surgery done on the wrong limb or organ."[17] In other words, these factual situations could be thought of as "deliberate deviations" from actual or implied consent, as Justice Traynor phrased it in the *Cobbs* case, discussed in the following section.

B. *Cobbs v. Grant: Intentional Deviation from the Consent*

The leading case on informed consent in California is *Cobbs v. Grant*.[18] In *Cobbs*, the plaintiff suffered from a duodenal ulcer. The defendant surgeon recommended surgery and explained the nature of the operation, but did not discuss the inherent risks. The operation was performed. Complications compelled two subsequent operations. Plaintiff was also hospitalized again for internal bleeding due to premature absorption of a suture, another inherent risk. The jury returned a general verdict against the defendant surgeon, which could have been based either on negligence or on failure to obtain informed consent to the treatment. The California Supreme Court reversed.

The bulk of the opinion is devoted to consideration of the requisites of disclosure, but on the classification of the tort, the court followed Prosser's suggestion that the matter involved standards of professional conduct and that the action was for negligence in failing to conform to the proper standard:

> Where a doctor obtains consent of the patient to perform one type of treatment and subsequently performs a substantially different treatment for which consent was not obtained, there is a clear case of battery.
>
> However, when an undisclosed potential complication results, the occurrence of which was not an integral part of the treatment procedure but merely a known risk, the courts are divided on the issue of whether this should be deemed to be a battery or negligence.
>
> . . .
>
> Although this is a close question, either prong of which is supportable by authority, the trend appears to be towards categorizing failure to obtain informed consent as negligence. . . .
>
> We agree with the majority trend. The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no

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[17]Jesse A. Goldner, *An Overview of Legal Controls on Human Experimentation and the Regulatory Implications of Taking Professor Katz Seriously*, 38 ST. LOUIS L.J. 63, 74 (1993).

[18]502 P.2d 1 (Cal. 1972).

> intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence.[19]

The facts in *Cobbs* sounded in negligence: "Defendant performed the identical operation to which plaintiff had consented. The spleen injury, development of the gastric ulcer, gastrectomy and internal bleeding as a result of the premature absorption of a suture, were all links in a chain of low probability events inherent in the initial operation."[20] On remand, the physician prevailed over the patient.[21]

III. POLICIES BEHIND THE DOCTRINE OF "INFORMED CONSENT": PATIENTS' SELF-DETERMINATION VS. DOCTOR'S PATERNALISM

The policy issues behind the doctrine of informed consent are succintly analyzed in the leading tract on the consent doctrine, *The Silent World of Doctor and Patient*, published in 1984 by Jay Katz.[22] Dr. Katz discusses the birth and development of the doctrine of informed consent and observes that the choice between battery and negligence "disguis[es] a basic policy choice between patients' self-determination and doctor's paternalism."[23] Negligence prevailed because judges perceived battery as too harsh to doctors.[24]

Employing the examples mentioned by Justice Traynor in *Cobbs*, wholly unauthorized surgery contrary to the patient's express instructions is the most arrogant. Society may well agree with the surgeon that the operation was justified to save the patient's life, to improve it, or perhaps to heal the patient

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[19] *Id.* at 8-9 (citations omitted).

[20] *Id.* at 9.

[21] KATZ, *supra* note 13, at 80.

[22] *Id.* at 59-80. Other discussions of policy issues are found in Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 643-46 (1970); Alexander M. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340 (1974); Richard E. Simpson, Comment, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 NW. U.L. REV. 172 (1981); Gerald Dworkin, *Autonomy and Informed Consent*, *in* 3 PRESIDENT'S COMM. FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 63 (1982); and PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 35-65 (1987).

[23] KATZ, *supra* note 13, at 69.

[24] *Id.* at 68-71. *See also* Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 224-25 (1985) (arguing that battery establishes an "uncompromising base-line of protection for patients' self-determination," but "subjecting doctors to actions for battery . . . threatened to yield unacceptably harsh results"). For the view that recovery in battery still may be possible notwithstanding some (but inadequate) understanding of the proposed intervention, see Marcus L. Plante, *An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639 (1968).

and return him to the productive work force. But, in a free society, the cost to the individual is great; and the conference of this power on the medical profession is recklessly undemocratic. These are cases of "intentional deviation from consent," to use Traynor's terminology.[25] Whether the civil law must rectify this problem is not entirely clear; however, at least the quantum level of the case is distinguishable from the next class of cases in which the surgeon fails to reveal all of the risks of the surgery.

Failure to disclose all of the risks of the surgery is viewed by California courts as supporting a negligence cause of action. The doctor's paternalism and arrogance may well have fueled the failure, but in most cases a failure to advise of the risks will not rise to the level of an intentional attempt to mislead the patient and circumvent her consent. If it should rise to such a level, liability for battery should arguably attach.

IV. INFORMED CONSENT AND GHOST SURGERY

Two reported decisions have directly faced the issue whether surgery by a different surgeon brings liability for battery.[26] One case reverses a defense verdict where the final court failed to give a battery instruction. The other affirms a verdict where the jury made no finding that the defendant was negligent. Both cases apply the doctrine according to formula. Neither case satisfactorily deals with the public policy issues involved. Neither case asks if the same rule would apply if the substituting surgeon had been substantially more qualified than the surgeon to whom the patient had consented.

In *Perna v. Pirozzi*,[27] defendant urologists (here "X, Y, & Z") were part of a medical group that operated as a "team." Their regular practice was to decide just prior to an operation who was to operate. Plaintiff did not know of this practice. He had entered the hospital on the advice of his family physician for tests and a urological consultation. In the hospital, plaintiff was examined by Dr. X, who had previously treated plaintiff for a bladder infection. Dr. X recommended surgery for the removal of kidney stones. Plaintiff signed a consent form that named Dr. X as the surgeon.[28]

Plaintiff was operated on by Drs. Y & Z, who were unaware that only Dr. X's name appeared on the consent form. Post-surgical complications developed,

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[25]502 P.2d at 9.

[26]Other reported cases do not present the issue clearly. *E.g.*, Wilson v. Martin Memorial Hosp., Inc., 61 S.E.2d 102 (N.C. 1950) (emergency delivery, issue of agency); Kenney v. Piedmont Hosp., 222 S.E.2d 162 (Ga. App. 1975) (patient consented to replacement surgeon); Henry v. Bronx Lebanon Med. Ctr., 385 N.Y.S.2d 772 (1976) (patient impliedly consented to delivery of baby by experienced resident under direct supervision of patient's obstetrician). *See also* Robin Cheryl Miller, Annotation, *Recovery by Patient on Whom Surgery or Other Treatment was Performed by One Other Than Physician Who Patient Believed Would Perform It*, 39 A.L.R. 4th 1034 (1985).

[27]Perna v. Perozzi, 92 N.J. 446, 457 A.2d 431 (1983).

[28]The doctors could have adopted a consent form with all three names. In fact, the boilerplate consent forms of many hospitals name additional surgeons.

and plaintiff was readmitted to the hospital. There he learned that Y & Z had performed the surgery. Plaintiff sued. The trial judge did not instruct the jury on battery. Rather, the jury was instructed that plaintiff could only recover if the substitution of surgeons somehow caused his damages. The jury found for the defendants.

The Supreme Court of New Jersey reversed the judgment for defendants and remanded for a new trial. Adopting terminology from an opinion of the Judicial Council of the American Medical Association,[29] the court labelled the substitution of surgeons "ghost surgery," and held that it constitutes a battery, entitling plaintiff to "recover for all injuries proximately caused by the mere performance of the operation, whether the result of negligence or not".[30] The New Jersey Court summarized the law as follows: If the patient suffers no injuries except those which foreseeably follow from the operation, then she is entitled at least to nominal damages and may in an appropriate case be entitled to damages for mental anguish resulting from the belated knowledge that the operation was performed by a doctor to whom she had not given consent.[31] Battery, the court seems to say, should be reserved for cases of deliberate, material deviation from the patient's consent. In an appropriate case punitive damages may be assessed.[32]

The second case is *Pugsley v. Privette*.[33] In that case, plaintiff had given her consent because she understood that her OB-GYN would be present during the operation. When he did not appear, she testified that she revoked her consent. The defendants disputed plaintiff's story. The jury believed plaintiff and awarded her damages against the operating surgeon on the battery count, that is, without finding that he had been negligent. In affirming the award of damages, the Virginia Supreme Court wrote:

> It is immaterial to the issue of battery that the jury found that the operation was not negligently performed. And it avails little to argue now that no good purpose would have been served by Dr. Hall's presence, or that had Dr. Hall been present the same operation would have been performed and the same complications would have arisen. It was [plaintiff's] body on which the operation was to be performed, and the decision was one peculiarly for her to make.... The hazard to a physician of performing an operation without the consent of the

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[29] *See* Judicial Council of the American Medical Ass'n, Opinion 8.12 (1982), attached as Appendix; *see also "Questions and Answers,"* 209 JAMA 947 (1969) (describing the performance of surgery by a resident operating under the supervision of a surgeon, but without the consent of the patient, as a fraud and deceit); American College of Surgeons, "Statements on Principles," § I.A. (June 1981) (it is unethical to mislead a patient as to the identity of the doctor who performs the operation).

[30] 92 N.J. at 461, 39 A.L.R. 4th at 1029.

[31] *Id.*

[32] *Id.*

[33] 263 S.E.2d 69 (Va. 1980).

> patient is dramatically illustrated by this case. Had [plaintiff's] recovery been an uneventful one, the action most likely would not have been brought. But the recovery was anything but uneventful, and this was the risk the defendant took when he operated without consent.[34]

Traynor's formulation of the informed consent doctrine ("intentional deviation from the patient's consent") might have embraced the Virginia case, but it would not have extended to the New Jersey case, where the surgeons operated without knowing that the consent form only allowed Dr. "X" to do the surgery.[35] Even so, the Virginia case could have been decided using the tort of infliction of emotional distress. The Virginia patient had consented to the operation by the operating surgeon. The absent doctor's presence would have done nothing. The court's decision can also be explained on judicial economy grounds: Imposing liability served to affirm a modest award ($75,000) of damages for plaintiff's long-term suffering and disability, and to avoid a lengthy retrial.

V. JURY INSTRUCTIONS AND CONCLUSION

California *Book of Approved Jury Instructions* (BAJI) 6.10 reads in part,[36] "It is the duty of *a* [not *the*] physician to obtain the consent of a patient before treating or operating on the patient." Similarly, BAJI 6.10.5 in relevant part[37] speaks of "[w]here a physician or surgeon obtains consent . . . ." The wording of these instructions leaves room for the construction recommended by the author: an operation by a surgeon to whom the patient has not consented should not automatically vitiate the patient's consent. But in every case the patient has a

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[34] *Id.* at 75.

[35] "The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented." 502 P.2d at 9.

[36] BAJI 6.10 reads in its entirety:

> It is the duty of a physician to obtain the consent of a patient before treating or operating on the patient. Such consent may be express or may be implied from the circumstances. [However, if the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative [unless it is impossible or impracticable to obtain such consent because of an emergency as defined in these instructions].]

[37] BAJI 6.10.5 reads:

> The [performance of an operation] [or] [rendition of treatment] to which the patient has not consented is a battery.
>
> [Where a physician or surgeon obtains consent of the patient to one type of [treatment] [or] operation and subsequently [renders substantially different [treatment] [or] [performs a substantially different operation,] it is likewise a battery.]
>
> A battery renders the physician subject to liability for any injury resulting therefrom.

cause of action for infliction of emotional distress. Recovery for this eventuality was discussed in *Perna v. Pirozzi*:

> If an operation is properly performed, albeit by a surgeon operating without the consent of the patient, and the patient suffers no injuries except those which foreseeably follow from the operation, then a jury could find that the substitution of surgeons did not cause any compensable injury. Even there, however, a jury could award damages for mental anguish resulting from the belated knowledge that the operation was performed by a doctor to whom the patient had not given consent.[38]

APPENDIX

Judicial Council of the American Medical Association, Opinion 8.12 (1982), reads as follows:

> To have another physician operate on one's patient without the patient's knowledge and consent is a deceit. The patient is entitled to choose his own physician and he should be permitted to acquiesce in or refuse to accept the substitution. The surgeon's obligation to the patient requires him to perform the surgical operation: (1) within the scope of authority granted by the consent to the operation; (2) in accordance with the terms of the contractual relationship; (3) with complete disclosure of all facts relevant to the need and the performance of the operation; and (4) to utilize his best skill in performing the operation. It should be noted that it is the operating surgeon to whom the patient grants consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he or she contracts. The surgeon, in accepting the patient is obligated to utilize his personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship. He cannot properly delegate to another the duties which he is required to perform personally.
>
> Under the normal and customary arrangement with private patients, and with reference to the usual form of consent to operation, the surgeon is obligated to perform the operation, and may use the services of assisting residents or other assisting surgeons to the extent that the operation reasonably requires the employment of such assistance. If a resident or other physician is to perform the operation under the guidance of the surgeon, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent.

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[38] 39 A.L.R. 4th at 1029.

If the surgeon employed merely assists the resident or other physician in performing the operation, it is the resident or other physician who becomes the operating surgeon. If the patient is not informed as to the identity of the operating surgeon, the situation is "ghost surgery."