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accidental advantage gained by one party confirmed in the trial court through the surprise and unpreparedness of his adversary?

Hopefully, both of these problems may be alleviated under the new discovery rules which will furnish to both parties, well in advance of trial, all the relevant and material evidence in the case. Many more claims should now be settled without ever going to court as both sides are enabled to make a realistic appraisal of the true worth of the claim. But more important, it is another step forward in the transition from the common law adversary system to the present idea of a trial as a truth seeking process. The lawyer, whether presenting a claim or defending one, will have full opportunity to evaluate all the evidence, and present his case with maximum effectiveness. The ends of justice will be better served for it.

*James Sheridan*

### MEDICAL MALPRACTICE—RES IPSA LOQUITUR AND INFORMED CONSENT IN ANESTHESIA CASES

The scope of medical malpractice litigation includes many more theories of liability than merely a physician's negligence.<sup>1</sup> For example, a physician's liability to his patient may arise out of a contract wherein he promises a specific result or remedy.<sup>2</sup> These cases are rare, however, and in the absence of a physician's express warranty the courts will not find an implied warranty.<sup>3</sup>

There are a number of tort theories, in addition to negligence, upon which a patient-plaintiff may predicate the malpractice liability of a physician. A second theory of recovery is abandonment and is based on a physician's premature termination of service. A third theory is assault and battery, wherein the unlawful touching requisite for recovery is the use of a medical procedure to which the patient has not expressly consented. A fourth theory of recovery is *res ipsa loquitur*, while a fifth theory is based on the lack of informed consent, and sounds in deceit and misrepresentation.

The latter two doctrines, *res ipsa loquitur* and informed consent, are two prominent theories used by plaintiffs in medical malpractice suits.

<sup>1</sup> See Curran, *Problems of Establishing A Standard of Care*, MEDICAL MALPRACTICE 15, (Institute of Continuing L. Educ., 2d ed. 1966); Spence, *Preparing and Trying a Medical Malpractice Case*, ATL MED. MAL., at 60 (1966).

<sup>2</sup> Cartwright v. Bartholomew, 83 Ga. App. 503, 64 S.E.2d 323 (1951); Robins v. Finestone, 308 N.Y. 543, 127 N.E.2d 330 (1955); Helmes v. Day, 215 S.W.2d 356 (Tex. 1948).

<sup>3</sup> See Roberts v. Wood, 206 F. Supp. 579, 583 (S.D. Ala. 1962); Comment, 60 MICH. L. REV. 1153, 1155 (1962).

This comment will explore each of these two doctrines briefly and then consider their application in cases of injury and death by or while under anesthesia. The relatively high incidence of cases involving injuries occurring while a patient is anesthetized recommends discussion of these cases.

The problems involved in malpractice litigation are in many ways different from those of an ordinary tort litigation. To begin with, a malpractice plaintiff often has great difficulty availing himself of expert medical testimony because of the general reluctance of physicians to give adverse testimony in a suit against a fellow practitioner.<sup>4</sup> This reluctance has often been labeled a "conspiracy of silence."<sup>5</sup> Due largely to this problem, and to the extent to which it cripples a plaintiff's proofs, many courts allow a plaintiff greater latitude in his trial presentations.<sup>6</sup> This latitude includes allowing a jury to pass on medical questions which are not within the purview of a layman's general knowledge.<sup>7</sup> Another aid to the plaintiff is the doctrine of *res ipsa loquitur*. Its application in medical malpractice cases has been extended and, as will be seen, is somewhat more permissive than the application the doctrine enjoys in the customary negligence case.

In addition to the difficulties of proof in malpractice litigation, there is the problem of the physician-patient relationship. Because this fiduciary relationship involves a very personal and vulnerable trust and confidence,<sup>8</sup> a breach can give rise to litigation charged with emotion. For this reason a physician tortfeasor has a heavier burden of going forward than other tortfeasors.

A further difficulty arises in these cases from the special emphasis placed

<sup>4</sup> See Comment, 60 *Nw. U. L. Rev.* 834 (1966); Comment, 60 *Nw. U. L. Rev.* 852 (1966).

<sup>5</sup> LOUISELL & WILLIAMS, *TRIAL OF MEDICAL MALPRACTICE CASES*, ¶ 14.02-03 (1960) (discussion of physician's unwillingness to testify). In *Huffman v. Lindquist*, 37 Cal. App. 2d 465, 484, 234 P.2d 34, 46, Judge Carter of the Supreme Court of California said, in his dissent: "But regardless of the merits of the plaintiff's case, physicians who are members of medical societies flock to the defense of their fellow member charged with malpractice and the plaintiff is relegated, for his expert testimony, to the occasional lone wolf or heroic soul, who for the sake of truth and justice has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy."

<sup>6</sup> One aid is permitting the plaintiff to elicit expert testimony from the defendant physician when he is called as an adverse party, even over defendant's objection. *Oleksiv v. Weidener*, 2 Ohio St. 147, 207 N.E.2d 375 (1965).

<sup>7</sup> See Morris, *Medical Malpractice: Important Events of the Last Two Years*, 30 *INS. COUNSEL J.* 44 (1963) in which the writer assails application of *res ipsa loquitur* in *Klein v. Arnold*, 203 N.Y.S.2d 797 (Sup. Ct. 1960). In this case the court allowed jurors to pass on the skillfulness of an esophagoscopy which had resulted in a rupture of the esophagus.

<sup>8</sup> See *Cho v. Kempler*, 177 Cal. App. 2d 342, 349, 2 Cal. Rptr. 167, 171 (1960), wherein the court found that the trust and confidence reposed in the physician required his explanation of what had happened.

on the factual situation of each case,<sup>9</sup> and results in decisions which are often inconsistent. Liability is much less certain and predictable from the facts in malpractice litigations than in ordinary tort litigation, due largely to the plaintiff's difficulty of allocating fault. The doctrine of *res ipsa loquitur* can help a plaintiff surmount this and other difficulties in the prosecution of a medical malpractice case.

#### RES IPSA LOQUITUR

In the case of *Byrne v. Boadle*,<sup>10</sup> the court inaugurated the doctrine of *res ipso loquitur*, which literally means the thing speaks for itself. The essence of the doctrine is that it may be said that in the ordinary course of human experience such an injury would not have occurred unless the particular defendant had been negligent. The plaintiff is enabled, thereby, to get his case to the jury without having to illustrate the defendant's specific negligence.<sup>11</sup>

In malpractice cases this doctrine is especially valuable to the plaintiff due to the difficulties of finding proof and establishing fault and proximate cause.<sup>12</sup> However, it must be remembered that the physician is not a warrantor of cures.<sup>13</sup> Therefore, a mere bad result is not sufficient to invoke the doctrine of *res ipsa loquitur*,<sup>14</sup> unless it is one which does not ordinarily occur in the absence of negligence.<sup>15</sup>

<sup>9</sup> See *Biancucci v. Nigro*, 247 Mass. 40, 141 N.E. 568 (1923), wherein the admission of evidence as to a prior similar chloroform death was held error, because all other relevant conditions in the prior case were not shown to be similar to the death in instant case.

<sup>10</sup> 2 H. & C. 722, 159 Eng. Rep. 299 (1863).

<sup>11</sup> See *Morris*, *supra* note 7.

<sup>12</sup> See generally *Spence*, *supra* note 1, wherein he suggests suing all operating and attending personnel, *i.e.*, everybody involved, as a solution to the problem of pinpointing fault. The court, if it applies *res ipsa loquitur*, will require the multiple defendants to give an explanation as to fault and proximate cause.

<sup>13</sup> See Comment, 60 Nw. U. L. REV. 852 (1966). *Siverson v. Weber*, 57 Cal. 2d 834, 839, 372 P.2d 97, 99 (1962). The California Supreme Court said, in rejecting the application of *res ipsa loquitur* to the facts therein, "To permit an inference of negligence under the doctrine of *res ipsa loquitur* solely because an uncommon complication develops would place too great a burden upon the medical profession and might result in an undesirable limitation on the use of operations or new procedures involving an inherent risk of injury even when due care is used."

<sup>14</sup> *Rhodes v. De Haan*, 184 Kan. 473, 337 P.2d 1043 (1959). See also *Lane v. Calvert*, 215 Md. 457, 138 A.2d 902 (1958); *Robinson v. Wirts*, 387 Pa. 291, 127 A.2d 706 (1956); *Butler v. Molinski*, 198 Tenn. 124, 277 S.W.2d 448 (1955); *Nelson v. Murphy*, 42 Wash. 2d 737, 258 P.2d 472 (1953).

<sup>15</sup> See *e.g.*, *Cho v. Kempler*, *supra* note 8; *Terhune v. Margaret Hague Maternity Hosp.* 63 N.J. Super. 106, 164 A.2d 75 (1960); *Bradshaw v. Wilson*, 87 Ohio App. 319, 94 N.E.2d 706 (1950); *Madis v. Stillwagen*, 38 Wash. 2d 1, 227 P.2d 445 (1951); *Olson v. Weitz*, 37 Wash. 2d 70, 221 P.2d 537 (1950).

The doctrine generally will not be applied in cases of erroneous diagnosis,<sup>16</sup> nor in cases of wrong choice of treatment.<sup>17</sup> The rationale for non-applicability is the concept that an honest error in judgment is not necessarily negligence.<sup>18</sup>

The practice of medicine involves a great deal of judgment and discretion. The certitude requisite to a finding of negligence by the reasonable and prudent man simply does not exist. Therefore, by way of a concession to the state of medical knowledge, a physician's acts are judged by the standard of medical practice in his community, rather than by the reasonable and prudent man.<sup>19</sup>

Application of the doctrine of *res ipsa loquitur* is contingent upon the pre-existence of certain conditions: an extraordinary injury unlikely to occur without negligence, caused by defendant's instrumentality without contributory negligence on the part of the plaintiff and in a situation where defendant has greater access to the facts. The first condition is that the injury or death out of which the action arose is one which would not ordinarily occur in the absence of negligence or in the exercise of due care.<sup>20</sup> The court must determine whether the injury would ordinarily have occurred without the presence of negligence.

Some courts have refused to apply the doctrine of *res ipsa loquitur* by saying that only expert testimony can establish this first requirement.<sup>21</sup> The majority of courts have taken the view that "the doctrine does not apply where common knowledge or experience is not sufficiently extensive to permit it to be said that the patient's condition would not have existed but for the negligence of the doctors."<sup>22</sup> However, in some cases the

<sup>16</sup> *Ayers v. Parry*, 192 F.2d 181 (3d Cir. 1951); *Crovella v. Cochrane*, 102 So. 2d 307 (Fla. App. 1958); *Voss v. Bridwell*, 188 Kan. 643, 364 P.2d 955 (1961); *Williams v. Chamberlain*, 316 S.W.2d 505 (Mo. 1958); *Poor Sisters of St. Francis v. Long*, 190 Tenn. 434, 230 S.W.2d 659 (1950). The rationale for rejecting *res ipsa loquitur* in cases of erroneous diagnosis, is the need for expert testimony to judge the nature of the error. See also, LOUISELL & WILLIAMS, *supra* note 5, ¶ 14.06, at 437.

<sup>17</sup> *Voss v. Bridwell*, *supra* note 16; *Dunn v. Beck*, 80 Mont. 414, 260 Pac. 1047 (1927); *Hodgson v. Bigelow*, 335 Pa. 497, 7 A.2d 338 (1939).

<sup>18</sup> *Langford v. Jones*, 18 Ore. 307, 22 Pac. 1064 (1890).

<sup>19</sup> See Wolfstone, *A Subjective Test of Professional Care*, ATL MED. MAL. (1966).

<sup>20</sup> English cases initially set out the first two requirements for the application of *res ipsa loquitur*; most common is the statement by Erle, C. J., in *Scott v. London & St. Katherine Docks Co.*, 3 H. & C. 596, 601, 159 Eng. Rep. 665, 667 (1865). See also 9 WIGMORE, EVIDENCE § 2509 (3d ed. 1940); PROSSER, TORTS 218 (3d ed. 1964); and for a decision setting out all four requirements, see *Ybarra v. Spangard*, 25 Cal. 2d 486, 489-90, 154 P.2d 687, 688 (1944).

<sup>21</sup> *Sanzari v. Rosenfeld*, 34 N.J. 128, 167 A.2d 625 (1961). The New Jersey Supreme Court rejected *res ipsa loquitur* and applied the common knowledge doctrine, attempting to avoid the problem of expert testimony.

<sup>22</sup> *Ayers v. Parry*, *supra* note 16, at 185.

courts have been willing to apply *res ipsa loquitur* if an expert first testifies that the event would ordinarily not occur without negligence.<sup>23</sup>

The problem of avoiding expert testimony is simply determining the degree to which common knowledge is sufficient to judge whether the injury would occur without negligence.<sup>24</sup> What is not within the jury's common knowledge must be established by reference to the standard of care in the medical community, supplied by expert testimony.<sup>25</sup> Often, expert medical testimony regarding the cause of injury or death is conflicting. The jury may then be allowed to weigh the testimony to determine which it deems more credible, but not to see which agrees with the jury's conception of causation.<sup>26</sup> The jury's common knowledge is insufficient in this regard and can have no bearing on the merits.

The cases in which the jury has been permitted to determine whether the injury was one which would occur in the absence of negligence generally fall into two specific categories, the sponge cases and cases involving an injury outside the field of operation. *Res ipsa loquitur* is most easily applied in the sponge cases, consisting of instances in which a surgical instrument or other foreign substance has been left in the patient's body during a surgical procedure. The cases include the leaving of sponges, forceps, surgical needles, rubber tubes, and Kelly clamps in the patient's eye, abdomen or other parts of the body.<sup>27</sup> In some of these cases the *res ipsa*

<sup>23</sup> *Wolfsmith v. Marsh*, 51 Cal. 2d 832, 337 P.2d 70 (1959); *Seneris v. Haas*, 45 Cal. 2d 811, 291 P.2d 915 (1955); *Costo v. Regents of Univ. of Cal.*, 116 Cal. App. 2d 445, 254 P.2d 85 (1953); *Farber v. Olkon*, 40 Cal. 2d 503, 254 P.2d 520 (1953); *Walker v. Distler*, 78 Idaho 38, 296 P.2d 452 (1956); *Fehrman v. Smirl* 20 Wis. 2d 1, 121 N.W.2d 255 (1963).

<sup>24</sup> See Comment, 60 MICH. L. REV. 1153, 1154 (1962); Comments, *supra* note 4.

<sup>25</sup> Common knowledge is the inherent limitation of the doctrine of *res ipsa loquitur*—the doctrine extends as far as a jury of laymen is able to infer. See *Jensen v. Linner*, 260 Minn. 22, 108 N.W.2d 705 (1961); *Robinson v. Weitz*, *supra* note 14; *Nelson v. Murphy*, 42 Wash. 2d 737, 258 P.2d 472 (1953); *Fehrman v. Smirl*, *supra* note 23. Therefore, the doctrine will apply if a jury is able to act without the aid of experts. See *Stickleman v. Synhorst*, 243 Iowa 872, 52 N.W.2d 504 (1952); *Buchanan v. Downing*, 74 N.M. 423, 394 P.2d 269 (1964).

<sup>26</sup> See *Forbis v. Holzman*, 5 Cal. 2d 407, 55 P.2d 201 (1936), where the court sustained a jury verdict for the plaintiff even though the weight of defendant's experts' opinions was greater than the weight of opinion of plaintiff's experts' opinion. *Contra*, *Remley v. Plummer*, 79 Pa. Super. 117 (1922), wherein the court held the jury not competent to pass on the question of whether defendant negligently administered the anesthetic, after conflicting expert testimony had been presented.

<sup>27</sup> *Dietz v. King*, 184 F. Supp. 944 (E.D. Va. 1960) (sponge); *Swanson v. Hill*, 166 F. Supp. 296 (D.N.D. 1958) (forceps); *Mondot v. Vallejo Gen. Hosp.*, 152 Cal. App. 2d 588, 313 P.2d 78 (1957) (rubber tubes); *Bowers v. Olch*, 120 Cal. App. 2d 108, 260 P.2d 997 (1953) (surgical needle left in the abdomen); *Leonard v. Watsonville Community Hosp.*, 47 Cal. 2d 509, 305 P.2d 36 (1956) (Kelly clamps); *Johnson v. Ely*, 30 Tenn. App. 294, 205 S.W.2d 759 (1947) (needle left in the abdomen); *Madis v. Stellwagen*, 38 Wash. 2d 1, 227 P.2d 445 (1951) (needle left in the eye).

loquitur inference has been rebutted by defendant's evidence,<sup>28</sup> and English courts have even refused to apply it on the grounds that the totality of circumstances under which the omission occurred are without the purview of the jury's common knowledge.<sup>29</sup>

The second category of cases, those involving injury to part of the body far removed from the field of operation, has generally sustained application of *res ipsa loquitur*.<sup>30</sup> The remoteness of injury is the essential factor in these cases and is the basis upon which the applicability of *res ipsa loquitur* is determined.<sup>31</sup> There have been many applications of the doctrine to cases not within these two categories. However, such application has not enjoyed general acceptance, and the results have often been inconsistent and unpredictable.<sup>32</sup>

Therefore, if the injury is one which ordinarily would not occur without negligence, and is not the result of a known calculated risk,<sup>33</sup> and this is within the jury's purview or is established as a preliminary matter by expert testimony, then the first condition for the application of *res ipsa loquitur* has been met.

The second condition required for application of *res ipsa loquitur* is that the injury or death to the patient be caused by an agency or instrumentality within the control of the defendant physician.<sup>34</sup> This includes

<sup>28</sup> *Landsberg v. Kolodny*, 145 Cal. App. 2d 158, 302 P.2d 86 (1956). In this case the defendant persuaded the jury that the emergency was responsible for leaving cotton gauze in the plaintiff's abdomen, and thereby overcame the inference of negligence.

<sup>29</sup> *Mahon v. Osborne*, 2 K.B. 14, 21-22, 1 Eng. Rep. 535, 540-41 (1939).

<sup>30</sup> *Dodson v. Pohle*, 73 Ariz. 186, 189-90, 239 P.2d 591, 593 (1952), *Frost v. Des Moines Still College of Osteopathy & Surgery*, 248 Iowa 294, 302-03, 79 N.W.2d 306, 311-12 (1956); *Higdon v. Carlebach*, 348 Mich. 363, 83 N.W.2d 296 (1957); *Jenson v. Linner*, *supra* note 25, at 34, 108 N.W.2d at 713; *Robinson v. Wirtz*, *supra* note 14 at 297-98, 107 A.2d at 710.

<sup>31</sup> The injury was found to be in too close proximity for application of *res ipsa loquitur* in *Ayers v. Parry*, *supra* note 16 at 187 and in *Engelking v. Carlson*, 13 Cal. 2d 216, 88 P.2d 695 (1939).

<sup>32</sup> Inconsistent decisions involving the application of *res ipsa loquitur* may sometimes be distinguished on the basis of factual differences. See *Emrie v. Tice*, 174 Kan. 739, 258 P.2d 332 (1953), and *Waddell v. Wood*, 158 Kan. 469, 148 P.2d 1016 (1944). The earlier decision rejected the doctrine and the latter decision applied the doctrine (both involved injuries from X-ray treatments).

<sup>33</sup> The calculated risk doctrine bars use of *res ipsa loquitur* whenever the injury was one which was bound to occur in a percentage of cases regardless of the due care of the physician. *Ayers v. Parry*, *supra* note 16; *Silverson v. Weber*, 57 Cal. 2d 834, 372 P.2d 97 (1962); *Farber v. Olkon*, 40 Cal. 2d 503, 254 P.2d 520 (1953); *Johnson v. Colp*, 211 Minn. 245, 300 N.W. 791 (1941); *Quinley v. Cocke*, 183 Tenn. 428, 192 S.W.2d 992 (1946). See PROSSER, *TORTS* 232 (3d ed. 1964). Comment, *Res Ipsa Loquitur and the Calculated Risk in Medical Malpractice*, 30 So. CAL. L. REV. 80 (1956).

<sup>34</sup> In Comment, 60 Nw. U. L. Rev. 852, 853 (1966) the writer criticises this traditional expression of the second *res ipsa loquitur* requirement. He points out that appli-

liability predicated upon the "captain of the ship" doctrine under which the operating physician or chief anesthesiologist is liable for the negligence of attending personnel.<sup>35</sup>

Establishing control of the instrumentality may be difficult due to problems of allocating fault and of generally establishing proof. These problems have prompted the increased application of *res ipsa loquitur* in malpractice cases,<sup>36</sup> and have caused the doctrine to be labeled a "rule of sympathy"<sup>37</sup> and "judicial socialization."<sup>38</sup>

A third condition precedent to application of the doctrine is that there must be no assumption of the risk or contributory negligence on the part of the injured party.<sup>39</sup> This condition, which was first stated by Wigmore,<sup>40</sup> has had some acceptance in the courts. However, in malpractice litigation, contributory negligence by the plaintiff may not bar recovery, but may merely mitigate damages.<sup>41</sup>

The final condition requires that the evidence necessary to fully explain and account for the injury must be more accessible to the defendant-

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cation of *res ipsa loquitur* in product liability cases doesn't require defendant's exclusive control, and suggests the condition be instead that the negligence points to the defendant.

<sup>35</sup> *Yorston v. Pennell*, 397 Penn. 28, 153 A.2d 255 (1959) (staff physician liable for acts of resident and intern over whom he had only vague supervisory duty to control); *Rockwell v. Stone*, 404 Penn. 561, 173 A.2d 48, 54 (1961) (surgeon responsible for acts of anesthesiologist); *Graddy v. New York Medical College*, 243 N.Y.2d 940 (A.D. 1963) (anesthesiologist liable for conduct of resident after a showing of some control). *Contra*, *Rudick v. Prineville Memorial Hospital*, 319 F.2d 764 (9th Cir. 1963) (radiologist not responsible for acts of X-ray technician as not sufficient evidence of master-servant relationship).

<sup>36</sup> In *Ybarra v. Spangard*, *supra* note 20, the court noted that the particular value of *res ipsa loquitur* is derived from the fact that the chief evidence of the true cause, whether culpable or innocent, is practically accessible to the defendant-surgeon but inaccessible to the injured person.

<sup>37</sup> *Morris*, *Medical Malpractice: Important Events of the Last Two Years*, MEDICAL MALPRACTICE, 169 Institute of Continuing L. Educ. (2d ed. 1966).

<sup>38</sup> *Id.* at 171.

<sup>39</sup> In *Enrie v. Tice*, *supra* note 32, the court applied *res ipsa loquitur* where defendant's exclusive control and plaintiff's lack of contributory negligence was pleaded. In *Waddell v. Wood*, *supra* note 32, the same Kansas court had rejected *res ipsa loquitur* where plaintiff's pleadings had not contained these two allegations.

<sup>40</sup> 4 WIGMORE, EVIDENCE § 2509 (1st ed. 1905).

<sup>41</sup> In *Morse v. Rapkin*, 24 App. Div. 2d 24, 263 N.Y.S.2d 428 (1965), the court distinguished between two types of malpractice cases. In one type the allegation is an ordinary charge of negligence against the defendant (usually a hospital). In this type of action contributory negligence of the plaintiff defeats the action. However, in a second type of suit the gravamen of the action is improper professional treatment by the defendant, and plaintiff's failure to follow instructions will not defeat the action, but rather reduce the damages.



physician than to the plaintiff-patient.<sup>42</sup> This is not so much a condition precedent as it is an "underlying policy" of the courts.<sup>43</sup> The defendant's greater access to the evidence has justified application of *res ipsa loquitur* where plaintiff's evidence was clearly insufficient.<sup>44</sup> If all the conditions precedent to the application of *res ipsa loquitur* are illustrated by the plaintiff to the satisfaction of the court, and the court recognizes the doctrine, it will give the jury an instruction as to how much evidentiary weight they are to attribute to the doctrine and what the procedural effect of applying *res ipsa loquitur* will be. This is an interesting and confused area which cannot be adequately dealt with in this comment. Suffice it to say there are three possible procedural effects which the courts have traditionally attached to the doctrine. The most widely accepted effect is the raising of an inference of negligence which the jury may accept or reject.<sup>45</sup>

A second procedural effect, attributed by a minority of jurisdictions, is the shifting of the burden of going forward to the defendant. By this view the doctrine establishes a presumption of negligence and the defendant must introduce some evidence to rebut it in order to avoid liability.<sup>46</sup>

The third possible effect of *res ipsa loquitur*, also a minority view, is the shifting of the entire burden of proof to the defendant.<sup>47</sup> The defendant must thus preponderate in order to sustain his defense. There has been strong criticism of the two minority viewpoints.<sup>48</sup> Such criticism is usually based upon the supposition that the effects attributed by the minority views abrogate our traditional concepts of fault liability.<sup>49</sup>

It must be remembered that many jurisdictions reject application of the

<sup>42</sup> See *Ybarra v. Spangard*, *supra* note 20, at 490; PROSSER, TORTS 218 (3d ed. 1964).

<sup>43</sup> Comment, 60 Nw. U. L. REV. 852, 853 (1966).

<sup>44</sup> In *Moore v. Bell*, 187 Tenn. 366, 215 S.W.2d 787 (1948), the defendants moved to dismiss because of plaintiff's failure to declare "in the language of the medical profession" the cause of death. The court denied the motion because of liberal pleading rules and because defendant had greater knowledge of the circumstances under which decedent died.

<sup>45</sup> See *Fehrman v. Smirl*, *supra* note 23; *Sweeney v. Erving*, 228 U.S. 233 (1913) (This view was adopted by the United States Supreme Court); PROSSER, TORTS 232-33 (3d ed. 1964); HARPER & JAMES, TORTS 1099 (1956).

<sup>46</sup> The actual number of states espousing this view is not certain. See PROSSER, TORTS at 234 (3d ed. 1964) where he lists five: Alabama, Arkansas, Colorado, Kentucky, and Pennsylvania. The uncertainty is due to the use of the term "presumption" by some courts when they intend the effect of an "inference."

<sup>47</sup> *Louisell & Williams, Res Ipsa Loquitur—Its Future in Medical Malpractice*, 48 CAL. L. REV. 252 (1960).

<sup>48</sup> Prosser, *The Procedural Effects of Res Ipsa Loquitur*, 20 MINN. L. REV. 241, 260 (1936). Cf. *Carpenter, The Doctrine of Res Ipsa Loquitur*, 1 U. CHI. L. REV. 519 (1934).

<sup>49</sup> *Ibid.* See also, Comment *supra* note 34, at 856.

doctrine of *res ipsa loquitur* or use some other procedural substitute with similar effect. Furthermore, the application of the doctrine in any one jurisdiction may be inconsistent and unpredictable. Therefore, meeting the requisite conditions for application of *res ipsa loquitur* is not an assurance that the court will apply the doctrine and give the jury an instruction as to its effect.

#### INFORMED CONSENT

A physician must obtain the patient's consent in order to perform any surgical procedure other than one required in an emergency.<sup>50</sup> This consent may be express,<sup>51</sup> implied in law,<sup>52</sup> or implied in fact.<sup>53</sup>

In *Schloendorff v. Society of New York Hosp.*,<sup>54</sup> the plaintiff was hospitalized only for an examination. She told the physician that he was not to perform any operation; however, while she was under ether anesthesia, the physician removed a tumor from her abdomen. In Judge Cardozo's opinion, he stated the case for the inviolability of the individual's body: "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 in damages."<sup>55</sup>

Performance of a surgical procedure without consent is a technical battery, and it is compensable on this theory without a showing of actual damages.<sup>56</sup> The question of consent is one of fact for the jury.<sup>57</sup> However, the doctrine of consent must be distinguished from the doctrine of informed consent.<sup>58</sup> The former arises from the social duty which prohibits a wrongful touching. The action is based upon a technical assault and battery, but it appears to be inconsistent because the intent, the malice usually attendant upon such action, is missing.

The doctrine of informed consent arises from a fiduciary duty on the

<sup>50</sup> *Gregoris v. Manos*, 35 Ohio L. Abs. 279, 40 N.E.2d 466 (Ct. App. 1941); *Hively v. Higgs*, 120 Ore. 588, 253 Pac. 363 (1927).

<sup>51</sup> *Farber v. Oklon*, 40 Cal. 2d, 503, 254 P.2d 520 (1953).

<sup>52</sup> *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912).

<sup>53</sup> *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120 (1929). The court will not usually find an implied consent to do additional surgery which becomes necessary during an operation if it relates to the reproductive organs. *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. Ct. App. 1953); *Rogers v. Lumbermens Mut. Cas. Co.*, 119 So. 2d 649 (La. App. 1960).

<sup>54</sup> 211 N.Y. 125, 105 N.E. 92 (1914).

<sup>55</sup> *Id.* at 129-30, 105 N.E. at 93.

<sup>56</sup> *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E.2d 25 (1956). See Plant, *Informed Consent—A New Area of Malpractice Liability?* MEDICAL MALPRACTICE 29, Institute of Continuing L. Educ. 29 (2d ed. 1966).

<sup>57</sup> *Wells v. Van Nort*, 100 Ohio St. 101, 125 N.E. 910 (1919).

<sup>58</sup> See Plant, *supra* note 56, at 31.

part of the physician to disclose all risks involved in a medical procedure.<sup>59</sup> The action is based upon deceit or misrepresentation by one occupying a position of trust and confidence.<sup>60</sup> However, there are limitations to the physician's duty to disclose. It "is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances."<sup>61</sup>

In *Salgo v. Leland Stanford Jr. Univ. Bd of Trustees*,<sup>62</sup> the court stated the reaches of the doctrine of informed consent.

[A] physician violates his duty to his patient and subjects himself to liability if he withholds any facts. . . . Likewise the physician may not minimize the known dangers . . . in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else [and] he sometimes must choose between two alternative courses of action. One is to explain . . . every risk[;] this may well result in alarming a patient who is already unduly apprehensive. . . . The other is to recognize that . . . the patient's mental condition is important and in certain cases may be crucial, and that in discussing the elements of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent. . . .<sup>63</sup>

There have been many cases in which the patient was not given sufficient facts to form the basis of an informed consent.<sup>64</sup> The risks requiring such an explanation vary from case to case.

In *Di Filippo v. Preston*,<sup>65</sup> the court said "the custom of the medical profession to warn must be established by expert testimony."<sup>66</sup> Where the risks are remote, the "general practice followed by the medical profession in the locality"<sup>67</sup> is usually not to disclose the risks. The use of the community standard to determine the extent of a patient's right to know the

<sup>59</sup> *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960); *Mitchel v. Robinson*, 334 S.W.2d 11 (Mo. 1960).

<sup>60</sup> See *Plant*, *supra* note 56, at 29.

<sup>61</sup> *Natanson v. Kline*, *supra* note 59 at 409, 350 P.2d at 1106.

<sup>62</sup> 154 Cal. App.2d 560, 317 P.2d 170 (1957).

<sup>63</sup> *Id.* at 578, 317 P.2d at 181.

<sup>64</sup> *Salgo v. Leland Stanford*, *supra* note 62; *Russell v. Harwick*, 166 So.2d 904 (Fla. App. 1964) (risks of hip surgery); *Bowers v. Talmage*, 159 So.2d 888 (Fla. App. 1963); *Natanson v. Kline*, *supra* note 59 (duty to disclose risks involved in cobalt radiation treatment); *Fiorentino v. Wenger*, 26 A.D.2d 693, 272 N.Y.S.2d 557 (1966) (hospital's liability for failure of independent surgeon to obtain informed consent to unorthodox and risky scoliosis treatment); *DiRosse v. Wein*, 24 A.D.2d 510, 261 N.Y.S.2d 623 (1965) (failure to warn of possible reaction to gold therapy used to treat rheumatoid arthritis); *Cf. Williams v. Menehan*, 191 Kan. 6, 379 P.2d 292 (1963) (sufficient disclosure to parents to enable them to give informed consent to cardiac catheterization of their child); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1964).

<sup>65</sup> 53 Del. 539, 173 A.2d 333 (1961).

<sup>66</sup> *Id.* at 550, 173 A.2d at 339.

<sup>67</sup> *Govin v. Hunter*, 374 P.2d 421, 424 (Wyo. 1962).

risks to which he is subject has been repeatedly assailed.<sup>68</sup> Furthermore, the exact nature of the physician's duty to disclose collateral hazards has been considered unclear and confusing by some writers.<sup>69</sup>

The duty to disclose, in addition to being qualified by the standard of medical practice in the community, is further qualified by therapeutic considerations. In *Roberts v. Wood*,<sup>70</sup> the court recognized this qualification, and noted that "the anxiety, apprehension, and fear generated by a full disclosure . . . may have a very detrimental effect on some patients."<sup>71</sup>

An exception to the requirement of consent is the emergency situation.<sup>72</sup> In an emergency the physician need not get an authorization nor need he explain the nature of the risks involved. In *Bennan v. Parsonnet*,<sup>73</sup> the New Jersey court extended the emergency doctrine and upheld additional necessary surgery performed by the defendant physician, even though no emergency existed. The court said there was an implied consent to do all things necessary while the plaintiff was anesthetized, even though not expressly authorized. However, except in true emergency situations the courts are not prone to find an extension of consent due to anesthesia, simply because the patient is unable to consent.<sup>74</sup>

It appears that expert medical testimony is best suited to determine whether an unauthorized procedure was called for by an emergency. The factors which must be considered in determining the justification for the unauthorized procedure are: (1) the imminence of the danger; (2) the seriousness of the risks in the additional necessary surgery to which the patient has not consented (these first two factors usually require expert medical testimony); (3) the impracticality of obtaining consent where the patient is anesthetized and the spouse or next of kin is unavailable; (4) the extent of the physician's prior disclosure to the patient

<sup>68</sup> Lambert, *Malpractice Liability Concepts Affecting All Professions*, ATL MED. MAL. 16: "I believe that the reaches of the physician's duty to warn should not be measured by the general practice followed by the local medical profession. The duty to warn should not be based upon the doctors' practices but upon the patients' needs for full disclosure of serious risks and the feasibility of possible alternatives. The determination as to whether this basic duty has been violated should not be wrested from the jury and the traditional decisional process and reposed in the indulgent and not-altogether-disinterested keeping of the defendant-doctor's colleagues."

<sup>69</sup> See Plant, *supra* note 56, at 34-35, wherein the writer comments on the various different standards used to define the physician's duty to disclose: "reasonable disclosure," "a certain amount of disclosure," "full disclosure," "substantial disclosure," and "under certain circumstances no disclosure may be justified." See also, 345 CALIF. L. REV. 217, 223 (1961).

<sup>70</sup> 206 F. Supp. 579 (S.D. Ala. 1962).

<sup>71</sup> *Id.* at 583.

<sup>72</sup> *Jackovach v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931); *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912).

<sup>73</sup> 83 N.J.L. 20, 83 Atl. 948 (1912).

<sup>74</sup> *Dietz v. King*, 184 F. Supp. 944 (D.C.Va. 1960).

and the patient's informed consent thereto; and (5) the scope of his general consent to the physician.

In addition to the physician's duty to disclose risks, there is another aspect of the doctrine of informed consent. The patient must allege that he would not have undergone the procedure had he been properly apprised of the risks inherent in the procedure. This allegation is difficult to rebut and is left to the jury.<sup>75</sup>

The last element necessary for application of the doctrine of informed consent is a showing of damages. This is necessary when the misrepresentation, including nondisclosure by the physician, relates to the collateral risks. A showing of damages is not necessary when the misrepresentation relates to the procedure itself, *i.e.* where basic consent was not even given for the type of touching which occurred.<sup>76</sup>

#### ANESTHESIA

Anesthesia involves the induced loss of sensation prior to a medical or dental procedure, having as its primary objective the avoidance of pain.<sup>77</sup> Many reported cases deal with injuries and deaths by or while under anesthetic. A prominent physician has said:

Errors in judgment or technique concerning either the anesthesia or the surgery, or a combination of the two, contribute close to 50% of the mortality in the operating room. It is here that death occurs, not only because of the gravity of the disease or the magnitude of the procedure, but also because someone in a responsible position ignored some fundamental principle of good therapy.<sup>78</sup>

The anesthetist is required to exercise that degree of diligence and skill which an ordinary practitioner engaged in similar practice in the community would exercise.<sup>79</sup> If the physician administering the anesthetic holds himself out to be a specialist the reasonableness of his acts will be determined by reference to the practice of similar specialists in the community.

<sup>75</sup> See *Consent to Surgery*, 11 CLEV.-MAR. L. REV. 241 (1962).

<sup>76</sup> See Plant, *supra* note 56, at 41.

<sup>77</sup> See generally, KEATING, ANAESTHETIC ACCIDENTS: THE COMPLICATIONS OF GENERAL AND REGIONAL ANESTHESIA (1961); WASMUTH, ANESTHESIA AND THE LAW (1961).

<sup>78</sup> Mannix, "Medicolegal Implications of Operating Room Deaths," in the N.Y. STATE JOURNAL OF MEDICINE, March, 1960, quoted in ATL MED MAL, at 42.

<sup>79</sup> Meyer v. St. Paul-Mercury Indem. Co., 225 La. 618, 73 So.2d 781 (1953); Ayers v. Parry, 192 F.2d 181 (3d Cir. 1951); Jackson v. Mountain Sanitarium & Asheville Agriculture School, 234 N.C. 222, 67 S.E.2d 57 (1951); Wells v. McGehee, 39 So.2d 196 (C.A.La. 1st Cir., 1949). An anesthetist is one who administers an anesthetic, usually a nurse. An anesthesiologist is a licensed physician specializing in the science and administration of anesthetics. Often the term anesthetist is used loosely to refer to anyone administering an anesthetic, including a physician; this application of the term is adopted by this comment.

Liability in malpractice cases falls upon he who has responsibility and control of the patient. An anesthetist's control is limited. He is only responsible for maintaining the patient in a comatose condition and not for any other aspect of the medical procedure.<sup>80</sup> If the anesthetist advises the operating surgeon to discontinue the surgery because the patient is not respiring well under the anesthetic, the anesthetist has discharged his duty.<sup>81</sup>

Control over the patient or instrumentality includes more than actual physical control. A physician or anesthetist may be deemed in control under the doctrines of respondeat superior and "captain of the ship." On the basis of these two doctrines, operating surgeons have been held liable for the negligence of anesthesiologists,<sup>82</sup> anesthetists,<sup>83</sup> hospital employees,<sup>84</sup> and student nurses.<sup>85</sup> These cases all involved injury by anesthesia. The vicarious liability of anesthesiologists has been sustained in cases of negligence by residents<sup>86</sup> and nurse anesthetists under the anesthesiologist's employ.<sup>87</sup> Hospitals also have a duty of care to a patient under anesthesia during the post-operative period.<sup>88</sup>

Peculiar problems beset these malpractice cases which involve anesthesia. To begin with, it is more difficult to determine if there has been negligence in anesthesia cases due to the many other possible causes of injury. Questions of proper treatment are less susceptible to explanation by expert medical testimony. For this reason, the sound judgment of the physician who administered the anesthetic is given greater weight.<sup>89</sup>

Once negligence is established the plaintiff must still show it was the proximate cause of the injury.<sup>90</sup> This causation problem is complicated

<sup>80</sup> *Cavero v. Franklin General Benev. Soc.*, 36 Cal. 2d 301, 223 P.2d 471 (1950); *Jett v. Linville*, 202 Ky. 198, 259 S.W. 43 (1924).

<sup>81</sup> *Robinson v. Crowell*, 175 Ala. 194, 57 So. 23 (1911); *Lawson v. Crane Hall*, 83 Vt. 115, 74 Atl. 641 (1909).

<sup>82</sup> *Rockwell v. Stone*, 404 Pa. 561, 173 A.2d 48 (1961).

<sup>83</sup> *Weiss v. Rubin*, 9 N.Y.2d 230, 173 N.E.2d 791 (1961). A physician may not delegate the administration of a spinal anesthetic. *Magit v. Board of Medical Examiners of the State of California*, 57 Cal. 2d 74, 366 P.2d 816 (1961).

<sup>84</sup> *Mazer v. Lipschutz*, 327 F.2d 42 (C.A. 3d Cir. 1963).

<sup>85</sup> *Sirochman v. Watson*, 88 Pittsb. Leg. J. 545 (Pa. 1940).

<sup>86</sup> *Rockwell v. Stone*, *supra* note 82.

<sup>87</sup> *Physician's Professional Liability—131. Questions and Answers, A.M.A.J.* #112 (Sept. 7, 1963).

<sup>88</sup> See *Thomas v. Seaside Memorial Hosp. of Long Beach*, 80 Cal. App. 2d 841, 183 P.2d 288 (1947).

<sup>89</sup> *Louden v. Scott*, 58 Mont. 645, 194 Pac. 488 (1920). The difficulty in establishing negligence is the reason expert testimony is usually required in these cases.

<sup>90</sup> See *Boucher v. Laroche*, 74 N.H. 433, 68 Atl. 870 (1908), wherein the court sustained the jury's verdict for plaintiff, notwithstanding expert testimony that chloro-

in anesthesia cases by other factors. For example, the patient may very well have a predisposition to drug reaction; or, the drug itself may have factors predisposing to adverse reaction.<sup>91</sup> But regardless of the therapeutic effects of a drug, it is in some measure toxic.<sup>92</sup> Often the drug's value derives from the effect of its toxicity on the body. This applies to anesthetics as well, which work by depressing the sympathetic nervous system.

There are many other reasons why anesthesia cases involve difficulty for the plaintiff. The most obvious is the patient's inability to consent to necessary additional treatment while under an anesthetic. An unconscious patient is also unable to observe which of the operating personnel caused his injury. This is often cited as a justification for applying the doctrine of *res ipsa loquitur* and for compelling defendants to explain the circumstances out of which plaintiff's injury arose.<sup>93</sup>

#### RES IPSA LOQUITUR AND ANESTHESIA

The courts have traditionally expressed reluctance to apply the doctrine of *res ipsa loquitur* to cases of injury resulting from the administration of an anesthetic or the injection of a drug.<sup>94</sup> This reluctance has applied to malpractice cases generally. However, there appears to be a trend towards application of this doctrine in recent decisions and anesthesia cases present an especially strong argument for its application.<sup>95</sup> A

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form deaths may result from a pathological condition of the plaintiff, from broken bones causing an embolism, or from other independent causes.

<sup>91</sup> See Hollister, *Adverse Reaction to Drugs*, ATL MED MAL, pt. 8, 107, 110-11, 119 (1966). In *Mogensen v. Hicks*, 253 Iowa 139, 110 N.W.2d 563 (Iowa 1961), the court rejected the application of *res ipsa loquitur* because plaintiff's injury from an administration of a topical anesthetic into his urethra was shown to be an allergic reaction, the result of his own body chemistry and not of negligent medical attention.

<sup>92</sup> Block, *If In Doubt Leave It Out (Some Comments on Anaphylaxis)*, ATL MED MAL, 259, 261 (1966).

<sup>93</sup> In *Pliss v. 83rd Foundation Inc.*, 69 N.Y.S.2d 727, 729 (City Ct. 1947), the court said: "where a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct."

<sup>94</sup> *Ayers v. Parry*, *supra* note 79 (partial paralysis from spinal anesthetic); *Lyu v. Shinn*, 40 Hawaii 198 (1953) (death from administration of ether during a tonsillectomy); *Mogensen v. Hicks*, *supra* note 91 (allergic reaction to a drug); *Cummins v. Donley*, 173 Kan. 463, 249 P.2d 695 (1952) (infections from injection of drugs); *Toy v. Rickert*, 53 N.J. Super. 27, 146 A.2d 510 (1958) (nerve damage from injection); *Grantham v. Goetz*, 401 Pa. 349, 164 A.2d 225 (1960) (burns from injection of a drug).

<sup>95</sup> *Res ipsa loquitur* is an aid to the unconscious patient injured by or while under an anesthetic: *Wolfsmith v. Marsh*, 51 Cal. 2d 832, 337 P.2d 70 (1959); *Seheris v. Haas*, 45 Cal. 2d 811, 826, 291 P.2d 915, 923 (1955); *Ybarra v. Spangard*, 25 Cal. 2d 486, 490, 154 P.2d 687, 689 (1944); *Frost v. Des Moines Still College of Osteopathy & Surgery*, 248 Iowa 294, 302, 79 N.W.2d 306, 311 (1956); *Voss v. Bridwell*, 188 Kan. 643, 663, 364 P.2d 955, 971 (1961).

plaintiff has special difficulties proving up an action based on specific negligence; and, furthermore, the plaintiff's unconsciousness urges some concession by the courts.

In *Terhune v. Margaret Hague Maternity Hosp.*<sup>96</sup> the plaintiff suffered post-operative blistering, swelling and weeping of the facial tissues due to the effects of an anesthetic. The trial court granted defendant's motion for involuntary dismissal on plaintiff's opening statement. The New Jersey Supreme Court (appellate division) reversed and remanded applying the doctrine of *res ipsa loquitur*. The court said:

The present case presents other considerations bespeaking maximum tolerance for the plaintiff's posture—the fact of the patient's unconsciousness when the alleged negligent acts were taking place and the consequent pooling of all direct evidence of the occurrences in hostile hands, as well as the commonly known difficulty of obtaining expert proofs in support of a malpractice claim. . . .<sup>97</sup>

Although there appears to be a trend toward application of *res ipsa loquitur*, most courts refuse to apply the doctrine. Most significant is a notable inconsistency in the decisions in regard to the application or rejection of the doctrine.

The cases involving injury due to anesthetics and the application of the doctrine of *res ipsa loquitur* can be broken down into five categories. The categories include: (1) explosions during administration of the anesthetic; (2) broken needles during administration of the anesthetic; (3) the administration of harmful drugs or drugs containing a foreign, deleterious substance; (4) the administration of spinal anesthetics, and (5) the administration of excessive anesthetics.

Certain anesthetics are explosive while others are not and mislabeling or contaminating anesthetics has sometimes resulted in explosions. In *Dierman v. Providence Hosp.*<sup>98</sup> the plaintiff's physician arranged to remove her tonsils and a wart on her nose. Nitrous oxide, a non-explosive anesthetic, was to be used during removal of the wart, and ether, an explosive anesthetic, was to be used during the tonsilectomy. While the operating physician was removing the wart with an electric needle, an explosion occurred injuring the plaintiff. Evidence presented at the trial showed that uncontaminated nitrous oxide was non-explosive. The court applied the doctrine of *res ipsa loquitur* in this case and made reference to the failure of the defendant hospital to introduce any explanation for the explosion to rebut the inference of negligence.

<sup>96</sup> 63 N.J. Super. 106, 164 A.2d 75 (Sup. Ct., App. Div. 1960).

<sup>97</sup> *Id.* at 113, 164 A.2d at 79.

<sup>98</sup> 31 Cal. 2d 290, 188 P.2d 12 (1947). See also *Andrepoint v. Ochsner*, 84 So.2d 63 (La. App. 1955) (defendant hospital held liable under *res ipsa loquitur* for explosion).



In *Wilt v. McCullum*<sup>99</sup> the court rejected application of the doctrine of res ipsa loquitur. In that case nitrous oxide and oxygen were administered to the plaintiff and an electric needle precipitated an explosion. Expert testimony tended to show that there were impurities in the gas which was delivered to the hospital. The court said that a verdict for plaintiff under the doctrine of res ipsa loquitur could not be sustained because there was no showing of negligence on the part of the surgeon or the anesthetist.

The cases involving injury from the breaking of a hypodermic needle used to administer an anesthetic have not uniformly applied the doctrine of res ipsa loquitur. In *Tennant v. Barton*,<sup>100</sup> there was expert testimony that the needle, which broke in the plaintiff's throat, broke either because plaintiff moved or because the physician improperly manipulated the hypodermic needle. The court held that an inference of negligence could be drawn from the very occurrence of the accident. The court pointed out that some expert testimony had been heard and that the surgeon had responsibility for the condition of the needle.

In *Robinson v. Ferguson*,<sup>101</sup> the court rejected the doctrine of res ipsa loquitur. In that case the needle broke while the defendant dentist was injecting novocaine into the plaintiff's jaw. The court said that expert testimony must first establish negligence before the doctrine of res ipsa loquitur could be applied.

Where an injury is alleged to be due to the injection of a harmful drug in place of an anesthetic, res ipsa loquitur is seldom applied. The courts have generally rejected the doctrine in these cases because of plaintiff's inability to prove that the deleterious substance was the actual cause of the injury.<sup>102</sup>

The administration of spinal anesthetics has occasionally resulted in a patient's partial paralysis; but the doctrine of res ipsa loquitur has been rejected in most of these cases. In *Ayers v. Parry*,<sup>103</sup> the court withdrew from the jury the question of the anesthetist's liability and held the doctrine of res ipsa loquitur inapplicable. The doctrine was rejected after medical experts testified that in many cases involving spinal anesthetics it is the patient's adverse reaction that causes paralysis. The court said that the plaintiff had to show some negligent act by the defendant in order to recover. And, in *Hall v. United States*,<sup>104</sup> the doctrine of res ipsa loquitur

<sup>99</sup> 214 Mo. App. 321, 253 S.W. 156 (1923).

<sup>100</sup> 164 Wash. 279, 2 P.2d 735 (1931): See also *Alonzo v. Rogers*, 155 Wash. 206, 283 Pac. 709 (1930) (applying res ipsa loquitur to the breaking of a needle).

<sup>101</sup> 107 Ind. App. 107, 22 N.E.2d 901 (1939). See also *Smith v. McClung*, 201 N.C. 648, 161 S.E. 91 (1931) (rejecting res ipsa loquitur in a broken needle case).

<sup>102</sup> See *Lippard v. Johnson*, 215 N.C. 384, 1 S.E.2d 889 (1939).

<sup>103</sup> 192 F.2d 181 (3d Cir. 1951).

<sup>104</sup> 136 F. Supp. 187 (W.D. La. 1955).

was rejected following evidence that paralysis resulted only in a small percentage of cases apart from any fault by the physician who administers the spinal anesthetic.

There has been an increasing awareness of the calculated risks involved in certain medical procedures,<sup>105</sup> especially in the administration of a spinal anesthetic. In *Perko v. Stager*,<sup>106</sup> plaintiff was administered a spinal anesthetic during delivery of her baby. Partial paralysis ensued and plaintiff brought suit. At the close of all the evidence the court rejected the doctrine of *res ipsa loquitur*, saying:

What particular kind of knowledge can an ordinary person have of the administration, if you please, of a spinal anesthetic? . . . from the standpoint of the public there is an apprehension about having anybody administer spinal anesthesia. . . . I am not of the opinion that we can let this jury speculate as to whether the doctor—if the *res ipsa loquitur* applies in this case or not, whether they will find the prerequisite elements necessary to make that rule applicable.<sup>107</sup>

However, in *Seneris v. Haas*,<sup>108</sup> the court had applied the doctrine of *res ipsa loquitur* upon similar facts. Plaintiff was paralyzed after receiving a spinal anesthetic during delivery of her baby. Evidence showed that the plaintiff was in good health and had previously received a spinal anesthetic without incident. Evidence was also introduced showing some injury to the plaintiff's spinal cord where the injection was made in an area where it was bad practice to administer an anesthetic. The court submitted this case to the jury on both the doctrine of *res ipsa loquitur* and the theory of direct negligence.

Where plaintiff alleges that an operating room death was caused by excessive or improper administration of an anesthetic, *res ipsa loquitur* may apply. However, the application of the doctrine to these situations usually follows preliminary evidence by the plaintiff which shows defendant's fault. One such case is *Cavero v. Franklin Gen. Benev. Soc'y*,<sup>109</sup> in which a child suffering from a minor tonsil infection died on the operating table after being anesthetized. The court applied the doctrine of *res ipsa loquitur* against the defendant hospital, employer of the anesthesiologist, after expert testimony that the child died from an overdose of ether.

<sup>105</sup> See Morris, *Medical Malpractice: Important Events of the Last Two Years*, MEDICAL MALPRACTICE 169, 175, Institute of Continuing L. Educ. (2d ed. 1966).

<sup>106</sup> *Id.* at 173. (This case is unreported: 1960, Common Pleas Court Cuyahoga County Docket No. 686543).

<sup>107</sup> Morris, *supra* note 105, at 174-175.

<sup>108</sup> 45 Cal. 2d 811, 291 P.2d 915 (1955).

<sup>109</sup> 36 Cal. 2d 301, 223 P.2d 301 (1950). See also *Forbis v. Holzman*, 5 Cal. 2d 407, 55 P.2d 201 (1936); *Harris v. Wood*, 214 Minn. 492, 8 N.W.2d 818 (1943); *Sirochman v. Watson*, *supra* note 85.

The doctrine was rejected in *Sanzari v. Rosenfeld*,<sup>110</sup> wherein the patient had a heart disease and was being treated by her physician for hypertension, high blood pressure. She had gone to the defendant dentist to have a tooth refilled, and he had administered xylocaine and epinephrine to her as a local anesthetic. This anesthetic was contraindicated by the patient's hypertension and she suffered a stroke, dying shortly thereafter. The court, in rejecting the doctrine of *res ipsa loquitur*, said that the defendant's liability would only exist if he had failed to inquire sufficiently into the patient's general health. The court pointed out that the occurrence of death, without more evidence, is insufficient to warrant application of the doctrine.<sup>111</sup>

The cases involving application of *res ipsa loquitur* generally arise out of the situations illustrated above. However, there are many cases applying the doctrine that do not fall into these common categories. They include cases involving the swallowing of a nasal catheter,<sup>112</sup> the swallowing of a tooth "pulled" by dentist-anesthetist,<sup>113</sup> the post-operative discovery that plaintiff's wrist was somehow broken while he was anesthetized,<sup>114</sup> and others.<sup>115</sup>

#### INFORMED CONSENT AND ANESTHESIA

The doctrine of informed consent has been of increasing importance to plaintiffs. It facilitates submission of plaintiff's case to the jury without the need for expert testimony or proof of negligence.<sup>116</sup> This is possible

<sup>110</sup> 34 N.J. 128, 167 A.2d 625 (1961). See also *Williams v. Tarter*, 286 Ky. 717, 151 S.W.2d 783 (1941), wherein *res ipsa loquitur* was held inapplicable to the case involving allegations that excessive chloroform was administered during child-birth; *Klucken v. Levi*, 293 Mass. 545, 200 N.E. 566 (1936) (injury to plaintiff's eyes from ether anesthetic).

<sup>111</sup> See *Mitchell v. Atkins*, 36 Del. 451, 178 A.2d 593 (1935); *Nemer v. Green*, 316 Mich. 307, 25 N.W.2d 207 (1946). Some cases of death not necessarily involving *res ipsa loquitur* have resulted in liability where the defendant knew or should have known of the patient's peculiar condition, or illness, requiring postponement of the operation: *Stephens v. Williams*, 226 Ala. 534, 147 So. 608 (1933); *Van Sant's Adm'r. v. Overstreet*, 261 Ky. 58, 86 S.W.2d 1008 (1935); *Jackson v. Mountain Sanitarium & Asheville Agriculture School*, 234 N.C. 222, 67 S.E.2d 57 (1951) (child operated on while suffering from a common cold—death resulted).

<sup>112</sup> *Kemalyah v. Henderson*, 45 Wash. 2d 693, 277 P.2d 372 (1954).

<sup>113</sup> *Meyer v. St. Paul-Mercury Indem. Co.*, 61 So. 2d 901 (La. App. 1952).

<sup>114</sup> *Wolfe v. Feldman*, 286 N.Y.S. 118, 158 Misc. 656 (1936).

<sup>115</sup> Generally, *res ipsa loquitur* has been rejected in cases of death or injury during childbirth: *Hall v. United States*, *supra* note 104; *Seneris v. Haas*, *supra* note 108 (both involving spinal anesthetics). The doctrine has also been generally rejected in cases of injury (during administration of anesthetic) to male urinary tract: *Mogensen v. Hicks*, *supra* note 91; *Lippard v. Johnson*, *supra* note 102.

<sup>116</sup> *Morris*, *supra* note 105, at 181.

because it is based on a different theory of liability than most of the other medical malpractice suits that sound in tort.<sup>117</sup>

The doctrines of consent and informed consent have special significance in anesthesia cases, because once a patient is anesthetized he is unable to consent to any additional procedure which the surgeon finds necessary;<sup>118</sup> This additional procedure may only be conducted, without consent, if it is necessary to avoid risk of death or serious impairment of health.<sup>119</sup> However, it has been held, that there is an implied extension of consent to do whatever becomes necessary while the patient is anesthetized and therefore unable to consent.<sup>120</sup> Nevertheless, a surgeon's failure to disclose in advance all the reasonably foreseeable risks involved in the procedure may create liability under the doctrine of informed consent.<sup>121</sup>

A physician's duty to obtain an informed consent to the proposed procedure requires his full disclosure of the reasonable risks involved. This disclosure may include the risks involved in the administration of an anesthetic.<sup>122</sup> In the case of *Hall v. United States*,<sup>123</sup> however, the court refused to apply the disclosure requirement in the doctrine of informed consent to the risks in administration of a spinal anesthetic. The plaintiff, in the *Hall* case, entered the hospital for delivery of a baby. A spinal anesthetic was administered during the delivery and the plaintiff thereafter suffered paralysis. The court, applying controlling Illinois law, said that the use of some kind of anesthetic was a standard practice of which plaintiff was undoubtedly aware. Therefore, the plaintiff impliedly consented to the anesthetic by her entrance into the hospital. The plaintiff alleged the failure of the defendant to inform her of the risks involved in the proposed spinal anesthetic, but the court dismissed this allegation due to expert medical testimony illustrating the dangers involved in the use of any type of anesthetic, and that a spinal anesthetic was called for in this case.

While the doctrine of informed consent has not had uniform acceptance, it has had support in a great many cases,<sup>124</sup> and its value to the plaintiff

<sup>117</sup> See discussion of medical malpractice theories of recovery, in introductory material.

<sup>118</sup> See *Consent to Surgery*, 11 CLEV.-MAR. L. R. 241 (1962).

<sup>119</sup> *Supra* note 87, #17-31.

<sup>120</sup> *Brennan v. Parsonnet*, 83 N.J.L. 20, 83 Atl. 948 (1912).

<sup>121</sup> *Dietze v. King*, 184 F. Supp. 944 (D.C.Va. 1960).

<sup>122</sup> See Plant, *Informed Consent—A New Area of Malpractice Liability*, MEDICAL MALPRACTICE 29, Institute of Continuing L. Educ. (2d ed. 1966); See also the cases involving informed consent at *supra* note 64.

<sup>123</sup> 136 F. Supp. 187 (W.D.La. 1955), *aff'd*. 234 F.2d 811.

<sup>124</sup> *Supra* note 122.

is often noted.<sup>125</sup> The ease with which the plaintiff can get his case to the jury is only one aspect of the doctrine of informed consent; another is the ability of the plaintiff to recover a judgment based on the doctrine. In *Keister v. O'Neil*,<sup>126</sup> the plaintiff alleged that the administration of a spinal anesthetic to her was contrary to her express instruction and without her consent. The court, however, refused to set aside a judgment for the defendant because no damages had been shown, and the most that the defendant would have been liable for was nominal damages for a breach of contract and for a technical assault. Although the plaintiff's theory was based upon the doctrine of consent, rather than the doctrine of informed consent, the case may point out a danger inherent in both. Unless actual injuries were incurred during the unauthorized or undisclosed procedure, only a nominal recovery can be expected.

A recent case points out the value of the doctrine of informed consent in curbing experimental procedures. In *Florentino v. Wenger*,<sup>127</sup> the defendant hospital and the defendant physician were both found liable for the wrongful death of a patient. It appears that the physician had been trying to perfect a method of treatment for scoliosis, a curvature of the spine. His technique had resulted in spinal injuries in the past and it was not recognized as good medical practice in the community. The court held that the defendant physician had a duty to disclose fully and truthfully the experimental state of his technique. The defendant hospital, at which the physician had performed the operations, was not in any way connected with the physician except by way of availing its facilities to him. Nevertheless, the court held the hospital equally responsible for the failure to apprise plaintiff and the decedent of the risks involved.<sup>128</sup>

If plaintiff in a medical malpractice litigation is unable to use the doctrine of *res ipsa loquitur* to facilitate submission of the case to the jury, the doctrine of informed consent may be applicable. Informed consent does not require a showing of an injury that would not occur without negligence. Furthermore, application of the doctrine of informed consent presents no problems of proof of negligence or of showing causation. This all stems from the basic fact that *res ipsa loquitur* presupposes negligence and informed consent does not. The doctrine of informed consent presupposes a duty to disclose risks and a failure by the physician to make such disclosure.

<sup>125</sup> *Supra* note 105, at 181.

<sup>126</sup> 59 Cal. App. 2d 428, 138 P.2d 723 (1943).

<sup>127</sup> 272 N.Y.S.2d 557 (A.D. 1966).

<sup>128</sup> See Harolds, *Overcoming Problems of Proof in Malpractice Cases*, *ATL MED MAL* 69, 78-79, for a discussion of the problems of informed consent and the need for experimentation.

There is an effort by the medical profession to combat the increasing number of cases sounding in deceit and misrepresentation under the doctrine of informed consent. These efforts are directed at the preparation and distribution of "consent forms."<sup>129</sup> The idea behind the consent form is to find a uniform and routine method assuring that physicians will not perform a procedure for which consent has not been obtained. Unfortunately, broad blanket consent forms have been the product of these efforts. Consequently, the courts often construe these forms as constituting a consent merely to the procedure orally agreed upon.<sup>130</sup> In *Rogers v. Lumbermen's Mut. Cas.*,<sup>131</sup> the court took a dimmer view of the blanket consent form. The court found the authorization form to be "about completely worthless," and said that "since it fails to designate the nature of the operation authorized, and for which consent was given, it can have no possible weight under the factual circumstances of the instant case."<sup>132</sup>

#### CONCLUSION

The doctrines of *res ipsa loquitur* and informed consent represent significant incursions into the citadel of the medical malpractice defendant. However, the courts frequently reject these doctrines, and this is often due to plaintiffs' untoward reliance on the evidentiary value which they may contain. In the case of *res ipsa loquitur*, it is especially important that the plaintiff ferret out and present as much actual evidence and expert medical testimony as he can. By so doing, the plaintiff can aid the courts in their efforts to define the reaches of these doctrines with some uniformity.

*Robert Kopple*

<sup>129</sup> *Id.* at 84-85.

<sup>130</sup> *Valdez v. Percy*, 35 Cal. App. 2d 485, 96 P.2d 142 (1939).

<sup>131</sup> 119 So.2d 649 (La. App. 1960).

<sup>132</sup> *Id.* at 652.