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Phantom Tumors & Hysterical Women: Revising Our View of the *Schloendorff* Case

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Phantom Tumors and Hysterical Women: Revising our View of the Schloendorff Case

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Over the past thirty years, the doctrine of informed consent has become a focal point in discussions of medical ethics. The literature of informed consent explores the evolution of the principle of autonomy, purportedly emerging from the mists of 19th Century medical practice, and finding its earliest articulation in legal cases where wronged citizens asserted their rights against medical authority. A commonplace, if not obligatory, feature of that literature is a reference to the case of Mary Schloendorff and the opinion written by Judge Benjamin Cardozo by which the case is remembered. Commentators today applaud the prescience of Cardozo for an early articulation of what eventually would become bioethical orthodoxy concerning informed consent and its place as a bulwark of patient autonomy. They inevitably quote Cardozo's famous statement, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."¹ We should not make too much of this sound-bite repetition of Cardozo's dictum; it would be surprising to find a serious commentator who used the Schloendorff opinion as the foundation of an argument about the origins of informed consent. Nevertheless, the quotation occurs often enough in such arguments to make examining its provenance worth the effort.

The *Schloendorff* case was brought to address a claim of medical malpractice in which a surgeon was accused of operating on an unwilling patient. We know from the opinion that medical examination of Mary Schloendorff revealed a tumor that her doctors

wished to examine more thoroughly "under ether." She consented to the ether, but claimed at trial that she had withheld consent for surgery. By her account, the doctors operated while she was unconscious and despite her earlier objections. Schloendorff argued later that she lost fingers to gangrene as the result of the operation, and suffered injuries to her leg as well.

Consider how a leading text in biomedical ethics uses Cardozo's opinion to trace the development of autonomous choice through a chain of legal precedents:

The best known and ultimately most influential of these cases is *Schloendorff v. New York Hospital* (1914). Schloendorff used rights of "self determination" to justify imposing an obligation to obtain a patient's consent. Subsequent cases that followed and relied upon Schloendorff implicitly adopted its justificatory rationale.²

Other texts focusing specifically on the origins of informed consent pay similar homage to the *Schloendorff* case, designating it a touchstone for all manner of rights, including the right to bodily integrity, the "sanctity of the person," the right to refuse treatment, and medical self-determination. In general, it has become a starting point for most discussions of informed consent.³

Yet despite the attention given to Cardozo's opinion, little has been written about the *Schloendorff* litigation itself. An exploration of the records from the case might lead us to ask whether celebration of *Schloendorff* is warranted. When we encounter the *Schloendorff* opinion, are we applauding the first appearance of patient's rights or merely reveling in Judge Cardozo's penchant for phrasemaking? Did this

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case actually signal a sea change in the relationship between doctors and patients?

It is rarely clear in most discussions of the Cardozo opinion that Mary Schloendorff lost her case. That result is not only startling because of the way Cardozo ignored the absence of consent for dangerous and unwanted surgery, but also for its extraordinary deference to charitable immunity of hospitals, employing questionable arguments and contorted interpretations of the facts to reach a conclusion that would allow the case to be dismissed. The very Court that Cardozo sat on – New York's Court of Appeals – criticized the reasoning on charitable immunity in the Schloendorff case as “logically weak” only ten years after it was decided,⁴ and it was completely overruled in 1957 when the shield of non-profit status was discarded in New York as “out of tune with life about us.”⁵ Yet we still celebrate the case as a salute to patient autonomy.

It is instructive to view the narrative contained in the Cardozo opinion as a counterpoint to a contemporary news account as well as the story told by Mary Schloendorff during her testimony at trial. These contrasting treatments of what happened at the New York Hospital yield surprising insights about the practice of medicine, particularly surgery, the deference paid to the charitable work of hospitals, and the fate of patients – particularly women – who were the victims of medical malpractice in the first decade of the 20th Century. They also suggest that Cardozo was far from the godfather of informed consent some commentary would have us believe.

The Cardozo Opinion

The starting point in the *Schloendorff* story is the opinion of Benjamin Cardozo. His short legal essay is the tip of the historical iceberg – but the only truly visible point of reference for over ninety years since the case was decided. Cardozo ran successfully for a seat on the Supreme Court, a trial court in the New York State system, and took his place as a novice judge on January 5, 1914. Presiding over only six cases, he had barely tasted the life of a trial judge when New York Governor Martin Glynn appointed him to fill a vacancy on New York's highest appellate tribunal, the Court of Appeals. Cardozo was on the bench less than six weeks when he heard oral arguments in the *Schloendorff* case, and he rendered the now famous opinion just over two months later, on April 14, 1914.



Mary Schloendorff

By then the case had been in the court system six years. Cardozo was forty-four years old, and his inexperience and status as a temporary judge (he was later elected for a full term on the Court in 1917) belies the notion that the *Schloendorff* opinion was noteworthy because of its author's status. Cardozo's reputation was made in the twenty-four years after *Schloendorff*, when he wrote dozens of memorable opinions, eventually becoming the Chief Judge of the New York court. It was this reputation that would eventually bring him to the U.S. Supreme Court in 1932, where he remained until his death in 1938.⁶

Cardozo's opinion begins with a focus on the single fact that will determine the case's outcome: New York Hospital was a charitable institution and thus immune under state law from Schloendorff's claim. From its opening lines, the opinion fairly reeks with deference for the role of medical philanthropy. Cardozo tells us that the hospital has a history stretching back to 1771, and a pedigree that includes a “royal charter” from none other than George III. Its *raison d'être* is “the care and healing of the sick.” It is not a business enterprise, and has neither stock nor profits. Care and boarding are provided for free to those who need them; even paying patients are charged only seven dollars a week for lodging. It is, most certainly, a charitable institution.⁷

Cardozo then turned to a terse description of the plaintiff, Mary Gamble Schloendorff, and her medical concerns. She arrived at the hospital in January, 1908, her complaint being “some disorder of the stomach.” She became a patient at the hospital, paying the charge for boarding of \$7 a week. After several weeks a doctor there discovered a lump, which proved to be a fibroid tumor. Another physician advised an operation.⁸

Cardozo reluctantly repeated what was apparently the most troubling result of the surgery – that “gangrene developed in her left arm, some of her fingers had to be amputated, and her sufferings were intense.” For purposes of discussing the legal claims that were made in the case, he allowed that this account must be tentatively accepted “even if improbable.”⁹

Cardozo continued with a recitation of the legal posture of Schloendorff's claim, in which “the wrong complained of is not merely negligence. It is trespass.” This was a critical point. Schloendorff was not claiming that she had suffered from the carelessness of the hospital and its surgeons. She charged that an operation on her was undertaken against her will and after she specifically stated her wishes to the contrary. Her

claim was couched in the language of battery, an intentional wrongdoing, recognized by the common law as offensive contact that yielded damage. Cardozo took the occasion of addressing the alleged battery to issue this ringing pronouncement on the right to self-determination in the medical realm.

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.¹⁰

Cardozo left some room for exceptions to this sweeping rule, noting that “cases of emergency where the patient is unconscious” might justify operations without consent. But he emphasized the novelty of Schloendorff's claim as separating it from the usual malpractice case, and he underscored the potential liability of the perpetrators of surgery without consent. He then established the legal distance between the hospital and its employees, asserting that the hospital, in making its facilities available for surgery, was not responsible for the potential misdeeds of its staff.

Again undercutting Mary Schloendorff's account, he conceded that “if we are to credit the plaintiff's narrative” it was the physicians who “ordered that an operation be performed on her in disregard of her instructions.” He separated the physicians from the hospital, as men serving their own profession, an “independent calling...sanctioned by a solemn oath and safeguarded by stringent penalties.” Whatever wrong may have happened, it may have been the doctor's fault, but it was not the responsibility of the hospital.¹¹

The opinion ended with the same bow to the role of medical philanthropy with which it began, endorsing the conclusion of the trial judge who directed the jury to reject the Schloendorff claim. It would be a shame, Cardozo declared, to rule against the hospital and thus “constrain charitable institutions” to limit their beneficence out of fear for liability. The staff of a hospital, “skilled physicians and trained nurses” all, serve “at the call of the afflicted,” with no thought for how deserving the patients may be. While a physician's malfeasance might cause harm to patients, the hospital assumed no liability for the doctor's faults.¹²

Charitable Immunity

The legal doctrine that insulated charitable organizations from legal liability for torts has a spotty American pedigree. It first entered the U.S. through a somewhat questionable back door when the Supreme

Court of Massachusetts embraced the concept in an 1876 case involving claims of a charity patient who suffered damages following surgery by a student-doctor.¹³ That court characterized the donations which supported the charity hospital as a trust that should be immune from certain damage claims. Authority for that proposition was not derived from American case law, but rather an English decision, *Holliday v. St. Leonard's*,¹⁴ which declared charities should not be responsible for the negligence of their agents. Unfortunately, the Massachusetts court neglected to note that the *Holliday* precedent had been obliterated by several cases, at least one of which was decided a full ten years earlier, resoundingly overruling *Holliday* and rejecting its logic.¹⁵ Nevertheless, U.S. courts repeated the argument of the Massachusetts decision, which soon morphed into two distinct assertions about the tort liability of hospitals.

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The first assertion was based on “Good Samaritan” logic: if a charity patient who stood to benefit from the benevolent ministrations of a free hospital was negligently harmed in the midst of receiving care, he should not be allowed to sue the hospital. That line of argument became known as the “implied waiver” theory: by making yourself available as a beneficiary of charity, you waive your right to later turn on your benefactor.

The second basis for denying liability was the doctrine known as *respondeat superior*. That Latin term (“let the master answer”) refers to the legal responsibility assumed by employers when their employees (“servants” in the common law parlance) harmed someone else by failing to exercise adequate care while doing their jobs. The harmful acts of the employee were imputed to the employer (the “master”).

There were problems with each of these legal theories. Many people arriving at hospitals were unconscious, others incapable of understanding the legal conditions of their admission. The idea that they had implicitly “waived” their right to bring suit was too much a fiction for some courts to accept.¹⁶ As for *respondeat superior*, it was not always easy to determine whether harms were caused by independent non-employee doctors, or by unpaid interns, students, nurses, orderlies and the like. Some were clearly under the control of the hospitals, others less so.

To complicate the picture further, almost as soon as charitable immunity rules began to be adopted in the U.S., the very notion of a pure “charity hospital” came under scrutiny. By the 1890’s, ostensibly “charity” hospitals had provisions for charging room and board to patients who could pay. Some hospitals also levied specific charges for professional services provided by doctors. These payments from financially capable patients were set aside to subsidize care for the indigent.¹⁷ The result was an awkward disconnect between the supposedly clear policy objectives of immunity as recited in state case law concerning hospitals, and the significantly more varied financial and administrative circumstances of hospitals and doctors.

The *Schloendorff* case occurred at a time when New York State courts had relied on both the “implied waiver” and *respondeat superior* theories to protect charitable hospitals. But the facts of the case made the use of either open to question. It was clear that at least as to room and board, Mrs. Schloendorff was a paying patient. It was also established that fees were paid to some physicians and surgeons who practiced at the hospital, and that those fees were sometimes collected by the hospital.¹⁸ More importantly, the *Schloendorff* case did not involve a charge of negligence, but trespass – and intentional tort. The New York cases on “implied waiver” covered negligence, not trespass.¹⁹

Fitting the roles of doctors and nurses into the theory of *respondeat superior* was even more problematic. While the visiting surgeon who performed the operation on Mrs. Schloendorff seems to have been a truly independent contractor for whose behavior the hospital was not responsible, the nurses filled a very different position. They were, in fact, employees of the hospital and under its control. But Judge Cardozo’s opinion strained not only to make them answer only to the doctor, but to completely divorce their responsibility from that of the hospital.

Mrs. Schloendorff testified that she asked the nurses repeatedly about the “ether examination,” stressing that she had not consented to surgery. The implication of these comments was that the hospital – via its employees the nurses – was on notice of the pending surgery and did nothing to stop it. To that suggestion, Cardozo said:

But nurses are employed to carry out the orders of the physicians, to whose authority they are subject. ...Whatever the nurse does in those preliminary stages is done, not as the servant of the hospital, but in the course of the treatment of the patient, as the delegate of the surgeon to whose orders she is subject.

Turning the role of the nurse as hospital employee on its head, Cardozo suggested that no one assisting in surgery will generate liability for the hospital despite the fact that a nurse may well have known the operation was improper. The nurse is considered an automaton under the complete thrall of the physician, unable to discern when things might be amiss. Even though the testimony indicated that nurses had heard Schloendorff’s concerns about surgery, Cardozo imputes to them a “see no evil” simple-mindedness, which he attributes to both their role and their training.

An ether examination was intended, and how soon the operation was to follow, if at all, the nurse had no means of knowing. Still less had she reason to suspect that it would follow against the plaintiff’s orders....About such matters a nurse is not qualified to judge. She is drilled to habits of strict obedience. She is accustomed to rely unquestioningly upon the judgment of her superiors. No woman occupying such a position would reasonably infer from the plaintiff’s words that it was the purpose of the surgeons to operate whether the plaintiff forbade it or not.²⁰

Cardozo admitted another potential exception to the immunity rule: “I can conceive” he suggested, “of cases where a patient’s struggles or outcries in the effort to avoid an operation might be such as to give notice” to hospital officials that some wrongdoing was afoot. But despite what Cardozo had learned from the trial record about Schloendorff’s cries of distress, this was no such case. The trial judge’s action – deciding the outcome without even submitting the case to a jury for a weighing of the facts – was allowed to stand. Cardozo’s biographer noted how restrictive Cardozo’s view of medical liability was in *Schloendorff*, which represented a “refusal to alter rules that exempted employers from liability.” “Not only did he accept and extend the immunity of a charitable hospital from liability for the negligence of physicians and nurses using its facilities, but he also extended the immunity to cover negligence of the hospital’s teaching staff.”²¹

The opinion, which sounds in part so sympathetic to the plight of victims who face medical abuse, is in its result extremely protective of medical prerogatives. The loss of a few fingers, however tragic, is not enough to justify changing the rule of charitable immunity; the critique of hypothetical “ministers of healing... [who] proved unfaithful to their trust” will not apply to the physicians at the New York Hospital, whose “solemn oath” has apparently not been breached.

This was, in fact, a very conservative opinion, yet one whose most memorable lines sound, in hindsight,

expansively sympathetic to patients suing doctors. Its description of Mary Schloendorff's surgery and its aftermath provides a contrast to other accounts, including one that was supplied by New York's press.

Schloendorff in the News

The contemporary public report of the *Schloendorff* controversy could not have been less sympathetic to the plight of beleaguered hospitals, nor more attentive to the alleged harms of Mary Schloendorff. *The New York World* carried this headline, announcing the beginning of the trial against the hospital where Mary Schloendorff endured surprise surgery.

HER PHANTOM TUMOR LEFT HER ARM USELESS
MRS. SCHLOENDORFF ASKS \$50,000 DAMAGES
FOR OPERATION

The story that followed introduced readers to the newlywed Mary Schloendorff. She was, said the paper, formerly an elocution teacher in San Francisco known as Mary Gamble. She claimed that surgery was performed on her without her consent and, as a result, she was "maimed for life." At trial in a New York courtroom, she told her story. The artist's courtroom sketch of Mrs. Schloendorff showed an elegant and dignified lady on the witness stand. Having survived the San Francisco earthquake in 1906, she suffered from "nervous shock." After entering the hospital in January 1907 she was prepared to leave when "some of the medical staff suggested that she undergo an examination" to determine her "exact physical condition." Mrs. Schloendorff "had a lump in her side" for five years and "of which her nurses knew." A doctor suggested an "ether examination" saying that she was too nervous to examine her otherwise.

To this she also consented, but stipulated that there be no operation at that time. The surgeons called the lump a "phantom tumor" and gave her the impression that it might be due to nervousness.

On recovery from the effects of the ether, Mrs. Schloendorff found that the surgeons had made incisions in her back and abdomen. In consequence, she testified, her fingers developed gangrene and she lost the use of her right arm.

The paper reported that the hospital denied all responsibility, claiming that "the operation was properly and skillfully performed, and that afterward the patient received proper care, attention and treatment."²² It did not report the result of the trial, cut short after four days when the judge directed the jury to render a verdict absolving the hospital of liability.

Court costs of \$292.62 were charged to Mrs. Schloendorff.²³ The case was appealed, but the first court to review the trial result upheld the decision against Schloendorff.²⁴

Mary Schloendorff's Account

The transcript of the *Schloendorff* trial provides us with a dramatic contrast to both the severely truncated, and at times hostile, narrative contained in the Cardozo opinion, and also the newspaper story that summarized the trial. Those other accounts masked what the records of the case reveal, unconstrained by the delicate conventions of the early 1900s. Mary Schloendorff had no ordinary tumor, nor was it on her arm. It was a fibroid mass in her uterus and the operation done against her will was a hysterectomy.

Mary Schloendorff introduced herself as the first witness at trial with the following statement.

I lived prior to November, 1906 in the City of San Francisco, California. I lived there nearly all my life. I was a teacher of physical training, voice, and culture, of reduction and development. My physical condition in the fall of 1906 was, I might say, perfect. The earthquake of San Francisco occurred on April 18, 1906. Well, I was greatly frightened and nervous, of course.²⁵

This admission of "nervousness" following the great earthquake was reiterated by several later witnesses, not as the explanation for Schloendorff's stomach problems, but as the basis for arguing that she was noncompliant as a patient and unreliable as a witness.²⁶

Fleeing her memories of the earthquake, she arrived in New York City in September of 1906, and lived with her adult son for a month before taking up residence in a rooming house. She sought medical advice from a doctor for what she characterized as "dyspepsia or indigestion." She took "Stewart's dyspeptic tablets and Bromo Seltzer" to alleviate her pain. In early December of 1907 she went to New York Hospital, which her physician had recommended. There she was treated by a Dr. Frederick H. Bartlett, who after approximately a month, told her she was "cured." "He told me I could go home at the end of the second week," she said, "but if I preferred to stay a week longer and gain strength, I could, as I was very much reduced in flesh, and I concluded to stay the week out."²⁷

But before she was discharged, Dr. Bartlett performed a physical examination that revealed a lump. This was no news to Mrs. Schloendorff, who stated that the lump in her side had been evident for about

five years.²⁸ Bartlett asked to bring in his colleague Dr. Lewis A. Stimson for a consult, but upon a second examination the lump had disappeared. Bartlett said it might be a floating kidney or “phantom tumor.” Stimson (the surgeon) attributed his inability to locate the tumor to Mary Schloendorff’s demeanor. He said that she was “too nervous, too rigid or too tense.” He recommended an “ether examination” so that the doctors could locate the mass.²⁹ Schloendorff was cautious about the nature of this examination.

But I asked Dr. Bartlett the next time that I saw him what was meant by an ether examination, and he said it meant to give the patient a little ether to quiet the nerves and relax the body. That it didn’t amount to anything; and I told him “I don’t want any operation Doctor.”³⁰

Dr. Bartlett advised her to see the surgeon while she was in the hospital to determine what the lump was. If it required surgery, she could return in the future.³¹ Schloendorff testified that her mind was made up to go home. She packed her suitcase and wrote a letter to her landlady saying that she was returning.³² The landlady would later confirm this sequence of events as part of her own testimony, and would introduce the letter into evidence.³³

But the night before Mary Schloendorff was to leave she was awakened by the night nurse who moved her to another ward. Again, toward midnight yet another nurse awakened her to prepare for the “ether examination.” Mrs. Schloendorff stated several times that she wanted no operation, but was reassured that only the “ether examination” would take place.

She was “swathed in antiseptic cloths...tied up like a mummy and placed back on the bed” to sleep. Upon rising the next morning, she was wheeled to another room where a man prepared to give her “gas” as a preparation for delivering the ether. She struggled, and tried to leave, but was restrained.

He had some apparatus there with a rubber tube and mouthpiece, and he took his hand and pushed against my forehead and pushed me back and put the mouthpiece to my mouth and said “Take a deep breath.” I was frightened at the gas and tried to get up, took a deep breath, I guess, and did not know any more.³⁴

When she regained consciousness, there was a large scar and pain. There was no contact with the surgeon for two weeks, nor was there any explanation of the nature of the surgery.³⁵ During the lawsuit the surgeon eventually testified how in order to remove the tumor,

he had to cut into the abdomen and tie off four arteries. All this was in preparation for the most critical part of the operation:

I...cut off the uterus at the junction of the neck and the body and took out that part; took out the upper portion. I took out all except the neck of the womb. I did take out the ovaries. I did not take out anything else.³⁶

He described the procedure in medical terms as “removal of the uterus, which was the seat of a fibromyoma, technical name of the operation being supravaginal hysterectomy.”³⁷

Mrs. Schloendorff reported strange occurrences following surgery. She had been moved to the basement to hide her cries of pain. From the colloquy between her lawyer and the nurses on duty, removal to this setting may have led to earlier legal actions by other patients who felt abused. Schloendorff testified that the night nurse ordered orderlies to carry her to the basement. On her third night there, a woman arrived from an ambulance in the street. She was “ragged and covered with blood.” Schloendorff observed this woman from her perspective “lashed to the bed.”

Schloendorff’s lawyers tried unsuccessfully to introduce evidence that orderlies had threatened “to break her neck”³⁸ if she didn’t muffle her cries. A nurse noted that Schloendorff “was keeping the other patients awake. She was in great pain.” The lawyers tried to suggest that the nurse had been arrested for assaulting another patient, but the questioning was not allowed.³⁹ Schloendorff’s testimony concerning her pain was particularly graphic.

I was cut across the stomach from hip to hip. I suffered a great deal, more than tongue can tell....My mouth was torn to pieces inside;...I suffered with pains in my arm and hand, coldness and numbness in my left hand.

But the responses of her doctors generally minimized her suffering, treating it as unlikely or imagined. Her surgeon believed that “it did not amount to anything, it would pass away.” Though Schloendorff recalled that her “hand was cold and the nails were blue,” the doctor “laughed and said that I was very imaginative.”⁴⁰

Upon making his rounds Dr. Stimson (the surgeon) “playfully punched me with his fist in the abdomen; in a playful way he said, ‘How are you, how do you feel old girl?’ I screamed in agony at the pain he gave me.”⁴¹ The same explanations for her “imagined” pain were given to her son Evan Gamble. “[S]he was suf-

fering no pain” the doctor said, “she only imagined it.”⁴² But the problem with her hand continued. She said her “left hand is useless. Fingers turned back and the cords – permanent adhesion, permanently turned back....One of my legs is affected almost as much as my hand.”⁴³

What possible association could there be between a hysterectomy, consent or not, and the withered hand that eventually brought Mary Schloendorff to court? A physician retained as an expert witness in the trial connected the two events. Dr. George Schoeps treated Mrs. Schloendorff from 1909 to 1911, eventually billing her for over \$100. He testified that an embolism formed as a result of the surgery caused the condition of her hand. He told the court:

An embolus is a foreign body in the circulation...A piece of fat, of coagulated blood or a piece of tissue. ...Now it is possible from this, and very likely from the wound surface, that some blood or foreign material went into the circulation and in the course of the blood circulated through the arteries and the heart...causing endocarditis.⁴⁴

Schoeps declared that surgery was not always necessary,⁴⁵ and that medical treatment was available for fibroid tumors. He also noted that an examination of such tumors could be done without using ether.⁴⁶ The treating doctors responded that the problem with Mrs. Schloendorff’s hand was her own fault. “She did not keep her hand elevated. The direction was not followed.”⁴⁷ Another doctor said that “...this arm was kept as quiet as possible, for a long period, by means of bandages, dressings, splints, and pillows, no one of which means could be used continually because of the patient’s extreme nervousness and impatience.”⁴⁸

At the time of Mrs. Schloendorff’s operation in 1907, surgery for fibroid tumors in women was a somewhat recent development. The first successful total hysterectomy for fibroid tumors was reported in New York in 1888.⁴⁹ Other available treatments included various medications, and the process of passing an electrical current through the uterus. The latter was a controversial but nevertheless common treatment for a while, purportedly used to shrink the tumor. There was also always the choice not to treat the tumor at all, and some practitioners suggested that women with no other symptoms than the mass itself “had better refuse to be operated on.”⁵⁰

Regardless of the efficacy of therapeutic alternatives, the danger of surgery motivated many surgeons to urge caution in elective cases. While some came

down soundly in favor of operating,⁵¹ others made it clear that it was the patient’s prerogative to decline the operation.⁵² Advising surgery was a “serious matter” when the mortality rate from operating ran as high as eight percent,⁵³ and though the rate had dropped measurably by the time Mrs. Schloendorff’s

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case was decided, medical debate over the proper indications for surgery provided “a perennial source of strife” among surgeons.⁵⁴

Approximately one month before she finally left New York Hospital, Mary Schloendorff was prepared for discharge. “I was told that I was cured” she said. “And they dragged me down, went through the formalities of a discharge from the hospital.”⁵⁵ Upon leaving the building, she collapsed in the street. Confronted with her condition, one of the doctors reportedly said “that was all a mistake; we did not intend for you to go.”⁵⁶ She remembered subsequently staying between five and six weeks more.

Under orders of the hospital management, Schloendorff was discharged in April of 1907 to St. Andrews convalescent home, where she stayed only briefly. She then moved to New York Graduate Hospital (two weeks) then to French Hospital (approximately three months). She was admitted to Bellevue Hospital for an operation on her hand, (two-three months) and then to Lebanon Hospital (five weeks) for convalescence the next summer. She was also treated at Cornell Hospital. At Bellevue she used her maiden name, Berry, “because I wished to hide myself from the world where no one would find me.” This attempted anonymity was later used as evidence to impeach her credibility as a witness, and undermine the rest of her testimony as unreliable.⁵⁷

Others testifying on Schloendorff’s behalf supported her recollections, one witness charging that a young surgeon described the botched operation as “all a terrible mistake.”⁵⁸ He later denied that comment. But she insisted on cross-examination: “Those were his words exactly.”⁵⁹

Consent

Mary Schloendorff’s prime contention, that surgery had occurred without consent, was vigorously contested by the defense. Dr. Lewis Stimson, the operating surgeon, stated that he kept no records of opera-

tions.⁶⁰ But he recalled that his encounter with Mrs. Schloendorff consisted of a manual examination of the tumor and these comments: "I told her I would remove it if she wanted it removed. She did not say she was opposed to an operation."⁶¹ Upon cross-examination he reiterated: "I told her if she wanted to have the tumor removed she could come over on the surgical side and I would take it out."⁶²

There were no other records to review on the question of consent because, as Dr. Bartlett testified, "I do not believe it is a custom...to give consent in writing to an operation."⁶³ Schloendorff's son Evan Gamble testified that he had been assured that no operation would be performed without notification; that was the custom in the hospital. Gamble insisted that he "did not wish her to be operated on even with her consent, that mine had to be obtained."⁶⁴ Dr. Stimson asserted that he would "never operate on a person without their consent." But neither would he consult with the relative who brought an adult patient to the hospital.⁶⁵ Like Dr. Bartlett, he declared that it was not the custom to consent in writing at the New York Hospital.⁶⁶

What was the usual custom concerning consent in 1914? As scholars have repeatedly pointed out, while traditional medical codes said little about consent, by the early Twentieth Century the expectation that the consent of patients was required before treatment was well settled. Particularly in cases involving surgery, patient wishes were usually followed.⁶⁷ By the time of Cardozo's *Schloendorff* opinion, the law was also clear in many jurisdictions, as Cardozo well knew, since he cited two such cases in the *Schloendorff* opinion.

One was the 1905 Minnesota Supreme Court decision in *Mohr v. Williams*. A trial jury awarded over \$14,000 in damages to Anna Mohr for the loss of hearing in her left ear following an operation by Dr. Cornelius Williams. She contended that she had only given consent to operate on her right ear. The doctor challenged the judgment of the trial court but the Minnesota Supreme Court upheld the decision, quoting a standard legal treatise on the "general rule" that

[t]he patient must be the final arbiter as to whether he will take his chances with the operation, or take his chances of living without it. Such is the natural right of the individual, which the law recognizes as a legal one. Consent, therefore, of an individual, must be either expressly or impliedly given before a surgeon may have the right to operate.⁶⁸

Echoing this perspective, the court thought the requirement of consent to be such a settled matter that "[i]t cannot be doubted that ordinarily the

patient must be consulted, and his consent given, before a physician may operate on him."⁶⁹ The choice of proper treatments, and the methods of delivery, were matters for a doctor's judgment, but the court could find no legal principle that would give surgeons "free license" to operate.⁷⁰ Moreover, a patient, like any other person, has a right to expect "complete immunity of his person from physical interference of others." The court characterized an unconsented surgery as a "violent assault."⁷¹

The second case cited by Cardozo was the 1906 Illinois case of *Pratt v. Davis* involving a woman who, like Mary Schloendorff, endured a hysterectomy. Parmelia J. Davis suffered from epilepsy and went to a sanitarium for treatment twice in 1896. Dr. Edwin H. Pratt provided "minor surgical treatment" during her first visit, but the second time, without any disclosure of his intentions, had her anesthetized with chloroform and surgically removed her uterus. Pratt testified that he intentionally deceived Mrs. Davis so that she would comply with the operation. The doctor excused his actions with the assertion that she was insane (she was, at the time of trial, committed to an asylum) and the surgery was a treatment for her condition. Additionally, he said he had a general consent from her husband to do whatever was in her best interest, and "implicit" consent from her since she was a voluntary patient at his facility.

Mr. Davis responded with a lawsuit for malpractice, using the theory that surgery without consent, regardless of therapeutic motive, created liability for "trespass" and justified damages. The suit resulted in a judgment against the doctor for \$3000 which doctor Pratt challenged on appeal to the Illinois Supreme Court. Ruling against Pratt, that court said that "...where the patient is in full possession of all his mental faculties...it is manifest that his consent should be a prerequisite to a surgical operation."⁷² Consent from someone with legal authority – spouse, family or others – was necessary for surgery even for mentally incompetent patients, except in cases of "great emergency."

Similar reasoning could be found in other cases, such as the 1913 Texas decision of *Rishworth v. Moss*, which not only required consent for surgery, but was very specific about who could provide it validly. Eleven year old Imogen Rishworth was taken to see Dr. Robert E. Moss by her sister, an adult. The sister gave consent for surgery to remove her tonsils, but the child died after an administration of chloroform for anesthetic purposes. The lawsuit, subsequently brought by Imogen's parents, was dismissed following an instruction by the trial judge who told the jury that consent of the adult daughter was equivalent to con-

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sent of the parents. But no evidence was presented suggesting that the daughter had the legal right to consent, even for her own sister.

On appeal, the Texas court declared that "...it seems to be reasonably established that a physician is liable for operating upon a patient unless he obtains the consent of the patient, if competent, and if not, of some one, who, under the circumstances, would be legally authorized to give the requisite consent."⁷³ An instruction that took away the legal authority of the parents to give or withhold consent was "absolutely and fundamentally wrong."⁷⁴

The 1913 Oklahoma surgical case of *Rolater v. Strain* was decided similarly. Mattie Strain stepped on a nail, and went to Dr. J. B. Rolater to have the subsequent inflammation drained. During this process the doctor found a bone he judged out of place, and removed it. Strain sued, claiming she had specifically asked that no bones be removed. Rolater said that removal was necessary as an emergency matter but the court disagreed, finding no emergency that would justify surgery directly contrary to the patient's stated wishes. It concluded that removing a bone without consent of the patient, "was therefore unlawful and wrongful, and constituted a trespass upon her person."⁷⁵ *Rolater*, like the cases cited by Cardozo, points to the same conclusion: At the time of *Schloendorff* the rules were reasonably clear that Doctors were expected to get consent before surgery both as a matter of medical custom and the law.

Conclusion

What then do we learn from Mary Schloendorff's account at trial in contrast to the Cardozo opinion? Despite the protests of hospital officials and their lawyers, and based on the literal testimony of Dr. Stimson the surgeon, it would appear that Mary Schloendorff gave no explicit permission for an operation. However else we credit her testimony, the surgeon's declaration reveals that the only defense he could muster was that she had not directly refused his services. According to him she never said yes, she just didn't say no. So while this might be a case about the need for simple consent, it is hardly a case about informed consent.⁷⁶ At best Cardozo's opinion merely

restates a maxim that could even at the time of trial be traced back through two hundred and fifty years in American law: surgery without consent is actionable; in some instances, it could even be considered a crime.⁷⁷

Consent was undoubtedly required of surgeons in the *Schloendorff* era, and the physicians who testified in Mary Schloendorff's trial said nothing to contradict that expectation. But the theory of informed consent, requiring an explanation of risks, benefits and alternatives to aid patient understanding and honor patient autonomy, took form only haltingly after World War II, and was nowhere to be seen in 1914 medical jurisprudence. The *Schloendorff* case is more properly read as a restatement of a none-too sturdy doctrine of charitable immunity.

Schloendorff is a reminder of the power of a judge's rhetoric when taken out of context. Cardozo's opinion is certainly not the paean to personal freedom it is cited so often to represent. Even on its own terms it dismisses the very person whose case cries out for a remedy at law. Cardozo gives one brief shining epigram that catches our imagination: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." But to Mary Schloendorff this was less than an empty promise. Applied to her the opinion might more properly read: "Abandon all hope of justice, Ye who enter here." As this analysis shows, Cardozo's reputation as the godfather of informed consent rests on a very slender reed.

Finally, what does the case say about the role of Schloendorff in medico-legal history? The case should be famous not for Cardozo's opinion, but instead, for the fact that he never mentioned the major harm done to Mary Schloendorff. Her complaint was not merely that she lost fingers and the use of a hand; she endured a hysterectomy she did not want and probably did not need. Her pains were called "imaginary" and her troubles described as the product of "nervousness." The court's decision in favor of the New York Hospital on grounds of charitable immunity cut against what by 1914 was an already well-established sensitivity toward the right to medical choice. Schloendorff is a monument to the power of a judge's

rhetoric; notwithstanding its place in the bioethics literature, it does not merit its current reputation as a progressive salute to autonomy and a milestone on the road toward informed consent. Despite Cardozo's articulation of the right of medical self-determination that made her name famous, Mary Schloendorff's claim was rejected and the full story of the wrongs she may actually have suffered was lost along the way.

References

1. *Schloendorff v. New York Hospital*, 211 N.Y. 125, 129-130 (1914).
2. "Informed Consent" in *Encyclopedia of Bioethics*, revised edition, vol. 3, W. T. Reich, ed. (New York: Simon & Schuster Macmillan, 1995): 1234.
3. See, for example, R. R. Faden and T. L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986), calling Schloendorff "a powerful rallying symbol in the informed consent literature" (28) and "a classic statement of the patient's right to self-determination" (123).
4. *Phillips v. Buffalo General Hospital*, 239 N.Y. 188 (1924).
5. *Bing v. Thunig*, 2 N.Y.2d 656, at 667 (1957).
6. R. Posner, *Cardozo: A Study in Reputation* (Chicago: University of Chicago Press, 1990): at 3.
7. *Schloendorff v. New York Hospital*, *supra* note 1, at 127.
8. *Schloendorff v. New York Hospital*, *supra* note 1, at 127-128.
9. *Id.*
10. *Schloendorff v. New York Hospital*, *supra* note 1, at 129-130.
11. *Schloendorff v. New York Hospital*, *supra* note 1, at 131-132.
12. *Schloendorff v. New York Hospital*, *supra* note 1, at 135.
13. *MacDonald v. Massachusetts General Hospital*, 120 Mass. 432 (1876). An extensive discussion of the history of charitable immunity for hospitals is contained in S. S. Bobbe, "Tort Liability of Hospitals in New York," *Cornell Law Quarterly* 37 (1951-1952): 419-438.
14. *Holliday v. St. Leonard's*, 11 C.B.H.S. 192, 142 Eng. Rep. 769 (1861).
15. *Mersey Docks Trustees v. Gibbs*, L.R. 11 H.L. Cas. 686 (1866).
16. See Bobbe, *supra* note 13, for cases rejecting the "implied waiver" rule.
17. M. J. Vogel, *The Invention of the Modern Hospital: Boston, 1870-1930* (Chicago and London: University of Chicago Press, 1980): 106-107. One commentator noted that long before *Schloendorff* states such as Rhode Island had concluded that even charitable hospitals could be held liable for the misadventures of surgeons, even though they received no pay from the hospital. E. B. Kinkead, *Commentaries on the Law of Torts*, vol. 1 (San Francisco: Bancroft-Whitney, 1903): at 209-212. The Rhode Island case (*Glavin v. Rhode Island Hospital*, 12 R.I. 411 [1879]) was cited by Cardozo for a different proposition, to demonstrate that a master/servant relationship does not usually exist between outside doctors and hospitals.
18. Court of Appeals, State of New York, Briefs and Records, Mary E. Schloendorff against The Society of the New York Hospital, (1914), Testimony of Henry Crane, at 176-177 (hereafter, Transcript).
19. Bobbe, *supra* note 13, at 427.
20. *Schloendorff v. New York Hospital*, *supra* note 1, at 134.
21. A. Kaufman, *Cardozo* (Cambridge, MA: Harvard University Press, 1998): at 252.
22. *New York World*, May 4, 1911, at 5.
23. Transcript, *supra* note 18, at 2.
24. *Schloendorff v. Society of New York Hospital*, 133 N.Y.S. 1143 (1912). Though the decision of the Appellate Division of the Supreme Court was rendered without an opinion, one judge noted his dissent.
25. Transcript, *supra* note 18, at 16-17.
26. Recurring references to Schloendorff's "nervousness" suggest a barely submerged theory of hysteria linking parts of the medical testimony. It was not uncommon for doctors to claim that surgical interventions such as hysterectomy would cure a woman's insanity. See, for example, "Insanity and Pelvic Lesions," *Medical News* 76, February 3, 1900, at 176. For a summary of the literature on hysteria, see M. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton, NJ: Princeton University Press, 1995).
27. Transcript, *supra* note 18, at 17-19.
28. *Ibid.*
29. Transcript, *supra* note 18, at 20.
30. *Ibid.*
31. Transcript, *supra* note 18, at 21.
32. Transcript, *supra* note 18, at 22.
33. Transcript, *supra* note 18, at 192; Transcript, *supra* note 18, "Plaintiff's Exhibit # 4," January 30, 1907 (Letter to Emily Lux), at 205.
34. Transcript, *supra* note 18, at 24.
35. Transcript, *supra* note 18, at 35.
36. Transcript, *supra* note 18, at 124.
37. Transcript, *supra* note 18, at 54.
38. Transcript, *supra* note 18, at 162.
39. Transcript, *supra* note 18, at 163.
40. Transcript, *supra* note 18, at 25-26.
41. Transcript, *supra* note 18, at 196.
42. Transcript, *supra* note 18, at 51 (Testimony of Evan Gamble).
43. Transcript, *supra* note 18, at 31.
44. Transcript, *supra* note 18, at 56-61.
45. Transcript, *supra* note 18, at 62.
46. Transcript, *supra* note 18, at 67.
47. Transcript, *supra* note 18, at 149 (Testimony of Dr. Otto Goehle).
48. Transcript, *supra* note 18, at 189 (Testimony of Dr. George M. Cottle).
49. R. Morantz-Sanchez, *Conduct Unbecoming a Woman: Medicine on Trial in Turn-of-the-Century Brooklyn* (New York: Oxford University Press, 1999): 77.
50. "Uterine Fibroids," *Health* 62 (August 1912): 179.
51. J. R. Goffe, "What Advice Should be Given to a Woman Suffering from Fibroid Tumor of the Uterus?" *Medical News* 82 (February 7, 1903): 247-249.
52. A. H. Goelet, "The Palliative Treatment of Fibroid Tumors of the Uterus," *Medical News* 83 (August 8, 1903): 258-260.
53. C. J. Webster, "A Consideration of Fibroid Tumors of the Uterus Based Upon a Series of Cases Treated Surgically," *Medical News* 86 (April 22, 1905): 764-768.
54. J. B. Deaver, "A Year's Work in Hysterectomy," *The American Journal of the Medical Sciences* 145 (April 1913): 469-474.
55. Transcript, *supra* note 18, at 57.
56. Transcript, *supra* note 18, at 38.
57. Transcript, *supra* note 18, at 40-44.
58. Transcript, *supra* note 18, at 45 (Testimony of Lillias M. Reeve).
59. Transcript, *supra* note 18, at 191, 192 (Testimony of George M. Cottle and Testimony of Lillias M. Reeve, in rebuttal).
60. Transcript, *supra* note 18, at 125.
61. Transcript, *supra* note 18, at 110.
62. Transcript, *supra* note 18, at 117.
63. Transcript, *supra* note 18, at 108.
64. Transcript, *supra* note 18, at 49.
65. Transcript, *supra* note 18, at 129.
66. Lest this issue seem too clear, yet another physician testified: "It is not the custom to operate without the consent of friends of the patient, such friends being matters of record in the office of the institution where they happen to be placed." Transcript, *supra* note 18, at 167 (Testimony of Dr. William M. Polk).
67. M. Pernick, "The Patient's Role in Medical Decisionmaking: A Social History of Informed Consent," in *President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* (Washington, DC: Government Printing Office, 1982) Appendices: Studies on the Foundations of Informed Consent, volume 3: at 4, 11.
68. E. B. Kinkead, *Commentaries on the Law of Torts*, vol. 1 (San

- Francisco: Bancroft-Whitney, 1903): 375.
69. *Mohr v. Williams* (95 Minn. 261, 268 [1905]).
70. *Mohr v. Williams*, *supra* note 69, at 269.
71. *Mohr v. Williams*, *supra* note 69, at 271.
72. *Pratt v. Davis* (224 Ill. 300, 305 [1906]).
73. *Rishworth v. Moss* (159 S. W. 122, 124 [Tex. 1913]).
74. *Rishworth v. Moss*, *supra* note 73, at 124.
75. *Rolater v. Strain* (137 Pac. 96, 98 [Okl. 1913]).
76. This is the conclusion of some of the most thorough commentary on the case as well; see J. Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984): 51-52. Katz is the only commentator I have identified in the bioethics literature who realized that the operation on Mary Schloendorff was a hysterectomy. His attention to the gynecological focus of the Schloendorff surgery is echoed by Kathleen E. Powderly, who also challenges Katz's view that consent was not commonly sought, while crediting the *Schloendorff* case with establishing the legal doctrine of informed consent. See K. E. Powderly, "Patient Consent and Negotiation in the Brooklyn Gynecological Practice of Alexander J. C. Skene: 1863-1900," *Journal of Medicine and Philosophy* 25 (2000): 12-27. One recent Cardozo biographer also identifies the hysterectomy amid an extensive analysis of the case, describing it along with similar personal injury cases that generated Cardozo opinions as an example of judicial deference to the learned professions, see R. Polenberg, *The World of Benjamin Cardozo* (Cambridge, MA: Harvard University Press, 1997): 108-114.
77. "From the earliest of times under the English, and later the American, common law, consent of the patient to medical treatment has been required in all but exceptional circumstances," C. W. Lidz and A. Meisel, "Informed Consent and the Structure of Medical Care," in *President's Commission 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* (Washington, DC: U.S. Government Printing Office, 1982), Appendices: Empirical Studies of Informed Consent, volume 2: at 317; for criminal prohibitions on surgery without consent, see *The Colonial Laws of Massachusetts Reported from the Edition of 1660*, "Chirurgions, Midwives, Physicians," 1649, L.2.P.3.