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 JUL 31 1957

MEDCL-NO. 2

Chief, Professional Division  
 Chief, Medical Plans & Operations Div.

Lt Col Rouse/67142/1p

XXXXXXX (IN TURN)

FROM : Chief, Legal Office

Recording of Consent of Service Members for Performance of Surgery, etc.

1. a. A review of applicable regulations indicates that medical and surgical (including dental) operations, treatments, and diagnostic procedures may be forcibly administered only in an emergency (par. 24a, AR 600-10). Also, when certain exceptions are met, immunizations may be forcibly administered (par. 24b, AR 600-10). Otherwise there is no authority to administer forcibly any of the above procedures, but proper action may be taken under UCMJ, if it is decided at Department of the Army level that the operation, etc. which is being refused is necessary to enable the service member involved properly to perform his military duties.

b. As the term "emergency" is not defined it is assumed that it is used in the normal sense. However, if a positive requirement to obtain consent of members of the armed forces were imposed, an emergency could well result from the delay encountered in cases in which the service member was incapable of giving consent, i.e., mental incompetency or minority and it was necessary to obtain consent from his next-of-kin or legal representative who was not readily available; which cases would not fall in the emergency category ordinarily. There is no regulatory requirement, however, at the present time that a service member be asked for his consent or consequently that such consent be recorded as there is in the case of a civilian patient (subpar. 4d, AR 40-200).

c. It is noted that the proposed Hospital Administration Manual (TM 8-262) specifies that SF 522, the only consent form now authorized for use in the Army (subpar. 8d, AR 40-424) cannot be used to record consent of active duty military personnel. This office objected to this restriction, by Comment 2, dated 19 July 1957, addressed to Chief, Medical Plans and Operations Division.

2. a. A review of the attached IG inspection files indicates that it is the practice in various Army hospitals to record consent of active duty military personnel on SF 522 for "surgical and other medical procedures". There is no indication as to exactly what procedures are included. It is assumed, for example, that immunizations are not included nor are such routine procedures as administering medications or performing blood tests. Additionally, there is no indication whether consent is obtained in all circumstances including for example, emergencies or where the service member is incapable because of unconsciousness, mental incompetency or minority of giving consent and consent must be obtained from his representative. It is noted that a minor who is a service member is considered to be legally emancipated by reason of military service except when he is 16 or under (U.S. v. Williams, 302 U.S. 46). It is not legally possible to enlist at age 16 or under and all such enlistments are void (U.S. v. Blanton, 23 CMR 128; 10 U.S.C. 3256).

b. In any event it would be an undue requirement to obtain consent from service members for all medical and surgical (including dental) operations, treatments, and diagnostic procedures. It is assumed that the current practice of

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obtaining consent from service members is limited to "surgical and other medical procedures" in which there is likelihood of danger or unusual risks to the patient. Otherwise it would be necessary to obtain consent from all military patients upon admission or in event they were not admitted at the time of treatment. While this is not normal civilian practice, it would not be necessary in civilian practice ordinarily, as there it may be presumed, the patient is voluntarily requesting medical care under most circumstances. No such presumption may be made in military practice, however.

3. a. Setting aside the medical considerations involved, ordinarily the reason for obtaining consent in civilian practice is to afford an additional protection against suits. This raises the question as to whether a similar necessity exists in the military service.

b. The only way the U. S. can be sued is under the Federal Tort Claims Act enacted in 1946 to permit suits against the United States for negligent acts or omissions of U.S. employees within the United States, its territories and possessions. This includes acts of malpractice by Army medical personnel. However, military personnel are excluded as claimants under the FTCA when the injury or death is incurred incident to service (*Feres v. U.S.*, 340 U.S. 135, 1950)). The term "incident to service" would include any injury or death incurred while on a duty status or while in a military facility or on a military post (*Brooks v. U.S.*, 337 U.S. 49) but not while off-post on pass (*U.S. v. Brown*, 348 U.S. 110; *Barnes v. U.S.*, 103 F. Sup 51; *Snyder v. U.S.*, 118 F. Sup 585). Thus, even if injury or death resulted from treatment not necessary to enable the service member properly to perform his military duties such as elective treatment (subpar. 4e, AR 40-108) or treatment incident to human research, the service member could not sue under the FTCA. It is apparent, therefore, that the Army is not exposing itself to suit by not requiring that consent be obtained and recorded from service members for the performance of subject procedures.

c. This is confirmed by analysis of malpractice suits under FTCA that have been reported to this office. In a total of 38 such actions since 1946, 11 were brought in cases in which a serviceman was the patient. Ten of these resulted in dismissal, all on the principle of the *Feres* case. The other case was settled out of court, the settlement being paid out of VA funds as the cause of action was based on death resulting from the transfusion of incompatible blood improperly labelled in a VA hospital.

4. Whereas in civilian practice, the legal basis for obtaining consent exists mainly as a protection against suit; in military practice, an additional reason is apparent where the treatment is not necessary to enable the service member properly to perform his duties, such as for elective treatment or treatment

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incident to human research. Clearly consent is necessary in such cases as an order to submit to such treatment would in all likelihood not be a lawful military order. There is no present regulatory requirement to obtain such consent.

## 5. A review of the above would indicate that:

a. There is no legal necessity that a military regulation be promulgated requiring the obtaining and recording of consent from service members for the performance of subject procedures.

b. If such a requirement were made it would be subject to numerous exceptions and cumbersome to operate. In addition to such exceptions as previously listed, others would have to be considered. For example, would all persons subject to military law be included within the term "service members" or should certain classes, i.e., retired members of the Regular Army, and reservists on short tours be excepted and placed in the same category as civilian patients (subpar. 4d, AR 40-200).

6. a. In addition to the above military considerations, the question of whether an Army physician or dentist is exposing himself to personal financial liability is raised. An action against an Army physician in his personal capacity rising out of injury or death caused by malpractice to a service member is legally permissible even though damages might be minimized by the benefits received by the member or his survivor from the United States. However, there have been no such cases reported to this office. Consequently, it appears that no Army medical personnel have been caused to suffer personal financial loss.

b. While a service member cannot sue the United States under the Federal Tort Claims Act for injuries or death incurred incident to service, there is no such restriction against others. Thus, a nonmilitary patient could sue either the U.S. under the FTCA, or an Army doctor individually for malpractice. Thus it is important to obtain proper consent from other than service members.

c. An example of this is afforded in the case of *Mees v. U.S.*, 225 F.2d 705 (1955) in which Mees, a veteran, brought an action under the FTCA alleging that a VA doctor had performed an unnecessary and uncalled-for operation on Mees' right leg and hip while Mees was under an anesthetic for an operation on his left leg and hip, for which Mees had given his consent. The court applying local Minnesota law as required under FTCA, held that action could not be brought under the FTCA as this Act excludes assault and battery, a willful tort. Under Minn. law, which is the same in most jurisdictions, an operation performed without the consent of the patient is considered to be assault and battery, regardless of lack of negligence on the part of the physician. There is no indication whether Mees, failing his remedy under the FTCA, then resorted to his

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remedy against the physician by suing him in his personal capacity.

d. Nevertheless it is debatable whether Army medical personnel would be better protected against individual suit by making a positive requirement in regulations relative to the obtaining and recording of consent from service members. As stated previously, any such requirement would be cumbersome and subject to numerous exceptions. Further, the obtaining of consent in itself is just one safeguard against a malpractice action. In addition, as above stated, there have been no such actions against Army doctors personally. In the event such an action is brought, the doctor being sued may have the action transferred to a Federal district court if the action is brought in a state or local court (50 U.S.C. 738, 28 U.S.C. 2576) and request that the U. S. Attorney represent him (pars. 11-14, AR 27-5). In the event he suffers financial loss, there is the possibility of an Army-sponsored private relief bill.

e. There is no legal objection, however, to permitting Army medical personnel to obtain and record consent when in accordance with local practice, and it does not interfere with military operations.

2 Incls  
n/c

RAYMOND COWARD  
Lt. Colonel, JAGC  
Chief, Legal Office

MEDDD-HO Chief, Legal Office  
Chief, Professional Division, OTSG  
(Attn: Chief Surgical Consultant)  
IN TURN

18 July 1957  
V. Linthicum/61737/eg

Chief, Medical Plans and Operations Division, OTSG

Annual General Inspections of Walter Reed Army Medical Center and  
Valley Forge Army Hospital, FY 1957.

1. Reference is made to paragraph 9b (2), Annual General Inspection of  
Valley Forge Army Hospital, FY 1957 and paragraph 10b (3), Annual General  
Inspection of Walter Reed Army Medical Center, FY 1957 relative to the neces-  
sity for recording consent of active duty military personnel for the performance  
of surgery and similar procedures.

2. Request this division be furnished comments upon which to base a  
reply to the Inspector General.

- 2 Incl  
1. AGI of VFAH.  
2. AGI of WRAMC.

THOMAS N. PAGE  
Colonel, MC

2023