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Life in the ER: The Trauma of the Emergency Exception Defense to Medical Battery

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In the world of television medical dramas, when an out of control, completely uncooperative patient who is a danger to himself bursts through the emergency room doors, the doctors go straight to work to figure out what is wrong and provide the proper care and treatment. Luckily, medical dramas are seldom subject to the plaintiff's bar and the Illinois court system. Most litigation in the real world of emergency medicine is centered on negligence, but medical battery has crept its way into complaints as alternative pleadings and should not be discounted.

The resurrection of allegations for medical battery may be attributed to *In re Estate of Darlene Allen v. Rockford Health Systems, Inc. et al*.[1] This decision focused on the emergency exception defense to medical battery. Unfortunately, the appellate court reversed the trial court's ruling in favor of the defendants and added a host of obstacles that medical providers may now have to overcome when faced with medical battery claims.

Following this decision, working up a medical battery claim may now be on par with any negligence allegations and, in some instances, could require more. As the legal and factual analyses unfold, defendants may face insurmountable hurdles in showing there is no genuine issue of material fact and, accordingly, may appear before more juries.

What is Medical Battery?

Medical battery arises out of three well established legal principles. First, common-law battery is the unauthorized touching of another person.[2] Second, a patient's consent is required before any medical provider can perform medical treatment of any kind to that patient.[3] Third, even if a patient's life is in peril, the patient has the absolute right to refuse any kind of medical treatment.[4] Thus, the plaintiff must establish the *prima facie* elements of a medical battery as (1) a total lack of consent to the procedure performed; (2a) the treatment was contrary to the plaintiff's will; or (2b) the treatment was at substantial variance with the consent granted.[5]

When pursuing a medical battery claim, the injured party typically seeks recovery by alleging that "there was no consent to the medical treatment performed, that the treatment was against the injured party's will, or that the treatment substantially varied from the consent granted."[6] In any of these situations, the medical provider has committed a battery because there was an intentional touching of the patient without consent.

What is the Emergency Exception Defense?

Just like common law battery, there are defenses to medical battery. The defense that most often lends itself to emergency medicine providers, surgeons, paramedics, and the like is the emergency exception defense. Borne out of the doctrine of implied consent, this defense was first noted in *Pratt v. Davis*, where the court observed that "various cases of which might be supposed of sudden and critical emergency, in which the surgeon would be held justified in major or capital operations without express consent of the patient, might be referred to the same principle of an implied license."[7]

The Illinois Supreme Court affirmed this defense,[8] culminating in a jury instruction codified in the Illinois Pattern Jury Instructions[9] as a three-pronged test. The instruction provides that a medical provider is not required to obtain consent to provide medical treatment if "an emergency arises and treatment is required in order to protect the patient's health, and it is impossible or impractical to obtain consent either from the patient or from someone authorized to consent for him."[10]

In *Curtis v. Jaskey*,[11] the court drew from an Ohio case in adding a subjective fourth element, which was based on a fifteen year old decision about an incapacitated patient's al-

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leged refusal to be kept on life support. As a result of *Jaskey*, and at odds with the I.P.I., there are now four elements to establish whether the emergency exception defense applies: (1) there was a medical emergency; (2) treatment was required in order to protect the patient's health; (3) it was impossible or impractical to obtain consent from either the patient or someone authorized to consent for the patient; and (4) there was no reason to believe that the patient would decline the treatment, given the opportunity to consent.[12]

This fourth element provides a tough hurdle in trying to secure summary judgment before facing a jury. The court extrapolated that "the emergency exception does not apply where the medical provider has reason to believe that the patient, if he or she had the opportunity to consent, would decline."[13] Following the *In re Allen* decision, establishing that there is no genuine issue of material fact as to each element, especially the fourth, requires more extensive discovery and most likely expert testimony.

What is a Medical Emergency and is Treatment Necessary?

The first and second elements necessary to establish the emergency exception defense may seem simple enough, but the big question is how to define a medical emergency. Is it when someone is brought to the emergency room appearing to be under the influence of a substance that needs to be expunged immediately for the patient's own safety? Is it when emergency surgery is required on an unconscious patient still under the effects of anesthesia when something goes awry? Is it simply when the medical provider believes that a medical emergency is on hand and medical treatment is necessary to protect the patient's health?

A board certified emergency medicine physician's own opinion that a medical emergency existed should be enough, but may not always carry the day.[14] Yes, it is generally true that an averment made in an affidavit or deposition that is uncontroverted will be taken as true. However, in dealing with the most likely scenario that medical battery is pled as an alternative theory of recovery, the plaintiff's counsel probably already has a physician's report and could certainly supply a counter-affidavit. If this occurs, the case will most likely proceed through expert discovery. At that point, if the plaintiff's expert affirmatively refutes one of the elements of the defense, the plaintiff has created a genuine issue of material fact as to the threshold element of a medical emergency and precluded a defense motion for summary judgment.[15]

In the two seminal cases discussing this defense, *In re Allen* and *Jaskey*, the plaintiffs did not present counter evidence of the existence of a medical emergency. Although litigation costs are of great concern, it is good practice to at least consult with an expert in order to satisfy this threshold element. After all, the baseline rule is that the determination as to whether a patient's medical condition constitutes a medical emergency must be established by expert testimony.[16]

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In re Allen provides little guidance as to when there is a necessity of medical treatment because it combines this analysis with whether a medical emergency existed. The court interpreted these two elements together when it discussed the defendant-physician's testimony that an emergency existed, requiring an immediate need to perform a drug screen to determine what drug the patient had taken so he could treat a potentially life-threatening overdose.[17] On the surface it is tough to find a situation when a medical provider would need to render medical treatment in order to protect a patient's health without the existence of a medical emergency. These two elements, although separate, are best argued as one.

When is it Impossible or Impractical to Obtain Consent?

A patient's lack of consent is the genesis of a medical battery claim. The emergency exception defense is rooted in the doctrine of implied consent.[18] When a medical provider meets a patient who is unable to consent and requires immediate medical attention, "it is logical to assume that the patient would consent from the circumstances."[19] However, as

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the *Jaskey* court forewarns, when a patient "has expressly refused to assent to some procedure, implying consent from the circumstances becomes problematic."[20] Ultimately, this boils down to a factual analysis, as evidenced by *In re Allen*.

The *In re Allen* patient is a prime example of what an emergency medical provider may face. Prior to even entering the emergency room, the patient was pulled over by a police officer and arrested for driving under the influence of drugs. The facts of the case are silent as to this point, but it appears the patient was in an inebriated state and the police officer drove the patient to the hospital against her will for a drug screening. In her car was a bottle of sleep medication with only seven of the 20 original tablets remaining.[21]

Although the facts indicate the patient signed a consent to medical treatment form, she clearly did not consent to the physician and other medical personnel's requests for a blood and urine sample. She was intermittently alert and sleepy, aggressive with the staff, uncooperative, and had slurred speech. She refused a drug screen. The physician assumed the worst when he observed her behavior, noticed the missing pills, and ordered the forcible extraction of blood and urine for analysis and medicine to counteract a possible overdose.[22]

The court paid close attention to the medical charting, which provided enough uncontroverted facts to show the patient was incapable of refusing consent to medical treatment. It honed in on the nursing staff's triage notes which showed the patient was disoriented, had slurred speech, was unable to ambulate without stumbling, and could not hold herself upright.[23] The nursing notes corroborated the physician's testimony that the patient was in an extreme state of impairment and lacked the capacity to consent to medical treatment.

When working up this element of the defense, the more testimony and records that support the plaintiff's lack of capacity the better. Procure deposition testimony from nurses, receptionists/clerks, EMTs, and police officers. Carefully review all charts, notes, incident reports, and even security camera tapes, which may be used as factual evidence of a patient's physical and mental state at the time a medical emergency unfolds.

It would also help to have every witness clearly articulate that they felt the patient was unable to make her own decisions and they believed it was impractical to obtain consent in a timely matter. The plaintiff will most likely make a fuss about the solicitation of opinion testimony from fact witnesses. However, a witness's personal opinion and observations during an interaction with a patient is vital to establishing your defense.

Is there a Duty to Obtain Consent from Another?

The second part of the consent element lends itself to a burden-shift and has potential to open the door for an institutional negligence claim. In asserting a defense, it is the defendant's burden to establish all elements. This is where the *In re Allen* court found that summary judgment in favor of the physician was inappropriate.[24]

Adding to the confusion is whether this creates a duty for the hospital, physician, or other staff to thumb through phone books, search engines, or call authorities to run a search for kin before rendering emergency medical treatment. This then could potentially create an end-around alternative pleading by which the plaintiff claims both medical battery and institutional negligence.

The pill bottle was not the patient's; it was her sister's. The court weighed heavily on the lack of any evidence that either the physician or anyone in the emergency room attempted to contact the patient's sister as someone empowered to give consent. When asserting an affirmative defense, it is the defendant's burden to establish evidence or testimony as to why obtaining consent from another was impossible or impractical.[25] The only evidence before the court on this issue was that the physician was not aware if anyone tried to contract the patient's sister, especially as her name was on the prescription bottle.[26] Although the court noted

that the plaintiff did not present any evidence indicating that it was possible and practical to obtain consent from her sister or someone else, neither was she obligated. Accordingly, the defense did not establish a lack of genuine issue of material fact as to the second part of this element and the court found that summary judgment was inappropriate in this case.[27]

It is interesting to note that the court theorized that there may not have been enough time to obtain consent.[28] However, the court did not expand on or provide any guidance as to that factor. Instead, it wrote that "this case does not involve a situation in which the court could make that inference."[29] This leaves the door open for plaintiffs to make creative arguments as to how easily one may find someone to consent in today's digital age. For example, the plaintiff could argue that a cell phone in a patient's pocket with a listing for "mom" could suffice.

This led to a minor, but interesting, aspect of the *In re Allen* decision in which the defendant-physician testified that he was not aware of any hospital protocol establishing how or when a physician is expected to obtain consent for an incapacitated patient.[30] One could foresee a future case, where the facts are just right, in which an allegation was pled for institutional negligence for lack of such a policy. This could result in a dangerous sliding scale for time to treat versus time spent looking for someone to give consent for a patient.

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Does the Treater Know if the Patient Would Actually Refuse Treatment?

The final element, addressing whether there was reason to believe that the patient would decline the treatment, given the opportunity to consent, was added by *Jaskey* after reviewing an Ohio case which discussed a unique circumstance that could raise a question whether a patient would continually refuse medical treatment. This derived from a case wherein life-saving resuscitation measures were administered to a patient who then had to be placed on life support. The parents sued, claiming that their daughter "expressly advised defendants that she did not wish to be kept alive by machines."[31]

After reviewing the Ohio court's decision, the *Jaskey* court found that when a patient's refusal of medical treatment is called into doubt by a change in circumstances, "the refusal becomes one factor to consider in deciding the factual question of whether the patient would have consented under the changed circumstances."[32] To support its finding, the *Jaskey* court quoted the following car accident example provided by the Ohio court:

> A terminally ill patient fully advised of an impending crisis might then be able to refuse treatments which would only prolong suffering, while a patient afflicted with a disease which would be terminal in several years and who had generally expressed a desire to die peacefully would *not* be denied treatment for injuries sustained in an automobile crash. Both doctor and patient would then be protected from statements not made in contemplation of the specific circumstances and the specific medical treatment required.[33]

Unfortunately, without reviewing this passage in the context of the entire Ohio court decision, this example read alone lacks clarity. Prior to coming up with that example, the Ohio court weighed on one hand whether a physician could "circumvent the express wishes of a terminally ill patient by waiting to act until the patient was comatose and critical" against the other hand, "the prospect of refusing to act in an emergency because the patient at some time voiced vague wishes not to be kept alive."[34]

What makes the addition of the fourth element to the emergency exception defense murky is that the *Jaskey* court dealt with a patient's allegations that she instructed her physician not to perform an episiotomy during childbirth.[35] The concerns weighed by the Ohio court were facts dealing with a terminally ill patient, an emergency need for life-support, and a parent's allegations of the patients' desire to refuse treatment.[36] These are wholly distinct fact patterns in separate states, with separate laws, and separated by fifteen years.

The only glaring similarity between these cases is that the defendant physician and the patient knew each other prior to the alleged unwanted medical treatment. A prior patient-physician relationship tends to be very rare when a patient is suddenly rushed to an emergency room in the middle of the night.

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Following *Jaskey*'s fourth element, the courts have not provided the defense bar any insight into how to prove this element. Indeed, the *In re Allen* court looked to the parties to offer guidance, but neither cited this fourth element in their arguments.[37] Unfortunately, because the court found a question of material fact existed as to the impossibility of consent, it was able to escape its opinion by barely addressing the fourth element.

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The *Jaskey* court's key consideration in adding this final element was whether the patient intended the refusal to apply in the way the treatment was rendered.[38] This element forces the medical provider to be a mind-reader in the middle of medical emergency. A scenario in which the medical provider knows the complete medical history and desires of the patient or happens upon a living will during treatment is extremely unlikely. Even in *In re Allen*, the facts seemed to demonstrate that the patient was a first time visitor to an emergency room physician. There was no prior patient-physician relationship, no previous chart or records, and certainly no means of effective communication in her inebriated state. [39]

We are left with a review of the record showing no one asked the physician if he thought the patient would refuse treatment if capable and that the physician had not previously treated the patient. Our only touchstone is a simple factual review without guidance as to legal interpretation.

Simply a Question of Fact for the Jury?

Illinois medical providers are well aware of a patient's right to refuse medical treatment.[40] However, as part of the dictates of the Hippocratic Oath, we would be shocked if a physician failed to jump in to render needed medical attention and save a life in an emergency. The emergency medical exception is supposed to be the medical provider's shield to battery claims. As the current state of legal interpretation stands, this defense is more likely to face a jury than prevail in a motion for summary judgment.

Following *Jaskey*'s peculiar additional element to the defense and *In re Allen*'s lack of guidance as to judicial interpretation, the defense is left with the burden of proving that if the patient was of sound mind and fully aware of the emergency situation, she would have consented to the emergency treatment. The whole basis for the medical battery claim is that the plaintiff did not consent to the treatment. Adding the fourth element may be appropriate in situations where the medical provider and patient had a previous relationship and the patient's wishes and desires were known. However, as it relates to emergency medicine, especially when a first time patient is brought into an emergency room at the wee hours of the morning with life-threatening circumstances, the fourth element acts primarily as a barrier to summary judgment.

(Endnotes)

[1] 365 Ill. App. 3d 378, 848 N.E.2d 202 (2d Dist. 2006).

[2] *Gaskin v. Goldwasser*, 166 Ill. App. 3d 1011-12, 520 N.E.2d 1085 (4th Dist. 1988).

[3] *In re Estate of Longeway*, 133 Ill. 2d 33, 44, 549 N.E.2d 292 (1989).

[4] *Id*. at 45.

[5] *Curtis v. Jaskey*, 326 Ill. App. 3d 90, 759 N.E. 2d 962 (2d Dist. 2001).

[6] *Hernandez v. Schittek*, 305 Ill. App. 3d 925, 930, 713 N.E. 2d 203 (5th Dist. 1999).

[7] 118 Ill. App. 161, 165-66 (1st Dist. 1905).

[8] *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906).

[9] Illinois Pattern Jury Instructions, Civil, No. 105.07 (2008).

[10] *Id*.

[11] 326 Ill. App. 3d 90, 96-76, 759 N.E.2d 962, 966 (2d Dist. 2001).

[12] *In re Allen*, 365 Ill. App.3d 378, 386, 848 N.E.2d 202, 211 (2d Dist. 2006).

[13] *In re Allen*, 365, Ill. App. 3d at 386, 848 N.E.2d at 211.

[14] *Id*.

[15] *See Adames v. Sheahan*, 233 Ill. 2d 276, 296, 909 N.E.2d 742, 753 (2009)(finding that a genuine issue of material fact precluding summary judgment exists where the material facts are disputed, or, if the material facts are undisputed, reasonable persons might draw different inferences from the undisputed facts.)

[16] *Id*. at 387, citing *Jaskey, supra*, n. 5 at 93, 759 N.E.2d at 964; *Schnidel v. Albany Medical Corp.*, 252 Ill. App. 3d 389, 398, 625 N.E.2d 114 (5th Dist. 1993).

[17] *Id*.

[18] *Jaskey*, 326 Ill. App. 3d at 96, 759 N.E.2d at 967.

[19] *Id*.

[20] *Id*.

[21] *In re Allen*, 365 Ill. App. 3d at 381, 848 N.E.2d at 207.

[22] *Id*. at 379-381, 848 N.E.2d at 206-07.

[23] *Id*. at 389, 848 N.E.2d at 214.

[24] *Id*. at 393-94, 848 N.E.2d at 217.

[25] *Paul H. Schedndener, Inc. v. Jupiter Electric Co.*, 358 Ill. App. 3d 65, 78; 829 N.E. 2d 818, 830 (1st Dist. 2005); *See also Daniels v. Union Pacific R. Co.*, 388 Ill. App. 3d 850; 904 N.E.2d 1003 (1st Dist. 2009) (as for motions to dismiss brought under 735 ILCS 5/2-619).

[26] *In re Allen, supra*, n. 12, 365 Ill. App. 3d at 394, 848 N.E.2d at 217.

[27] *Id*.

[28] *Id*.

[29] *Id*.

[30] *Id*.

[31] *Est. of Leach v. Shapiro*, 13 Ohio App. 3d 393, 397; 469 N.E.2d 1047, 1053 (9th Dist. 1984).

[32] *Jaskey, supra*, n. 5, 326 Ill. App. 3d at 97, 759 N.E.2d at 968.

[33] *Id*., quoting *Leach, supra*, n. 31, at 397, 469 N.E.2d at 1053.

[34] *Leach, supra*, n. 31, 13 Ohio App. 3d at 396-397, 469 N.E.2d at 1053.

[35] *Jaskey, supra*, n. 5, 326 Ill. App. 3d at 91-92, 759 N.E.2d at 963.

[36] *Leach, supra*, n. 31, 13 Ohio App. 3d at 396-397, 469 N.E.2d at 1053.

[37] *In re Allen, supra*, n. 12, 365 Ill. App. 3d at 394, 848 N.E.2d at 218.

[38] *Jaskey, supra*, n. 5, 326 Ill. App. 3d at 98, 759 N.E.2d at 968.

[39] *In re Allen, supra*, n. 12, 365 Ill. App. 3d 389-91, 848 N.E.2d at 213-15.

[40] *In re Longeway, supra*, n. 3, 133 Ill. 2d at 45, 549 N.E.2d at 298.