The Emergency Exception to the Informed Consent Rule – The Appellate Court Continues Its Narrow Construction


Obtaining the informed consent of a competent patient prior to the performance of a surgical procedure or other medical treatment is a fundamental concept of Illinois common law.1 Consent to treatment may take the form of expressed permission as reflected in papers signed by the patient in the doctor’s office or upon admission to the hospital, or may be implied from the circumstances present, as is more fully discussed below.2 Absent such consent, whether expressed or implied, a physician has no right to render medical treatment to a patient3 and may become liable for the tort of medical battery4 where consent is lacking;5 where the treatment exceeds the bounds of the consent given;6 or where the treatment is rendered against the patient’s will.7

The tort of medical battery does not require a showing of intent to harm or offend, nor does it require any physical consequences.8 Medical battery can be present even in so-called “helpful intent” cases,9 and the essence of the tort is satisfied as long as the “touching” of the patient is unauthorized, exceeds the extent of the consent granted by the patient, or is done contrary to the patient’s wishes.10

In one of the earliest cases involving an alleged medical battery, Justice Benjamin Cardozo, then an Associate Judge of the New York Court of Appeals, and later an Associate Justice of the Supreme Court of the United States, said:

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.11
Besides battery, a cause of action involving the alleged absence of informed consent can also take the form of a negligence-based suit for malpractice wherein a plaintiff must establish that: “(1) the physician had a duty to disclose material risks; (2) he failed to disclose or inadequately disclosed those risks; (3) as a direct and proximate result of the failure to disclose, the patient consented to treatment she otherwise would not have consented to; and (4) the plaintiff was injured by the proposed treatment.”

In such cases it should be noted, as the trial judge in the case of *Taylor v. County of Cook* correctly pointed out, that informed consent is judged by an objective standard, not a subjective one, making the relevant inquiry whether “after proper disclosure, a prudent person would have nevertheless proceeded with the proposed treatment.”

One of the earliest Illinois cases to discuss the essential nature of informed consent was the 1905 case of *Pratt v. Davis*. The *Pratt* case involved a performance of an unauthorized hysterectomy upon a woman who had allegedly been told that only medical treatment, and not surgery, would be necessary for her care. While the plaintiff was under the influence of a drug administered by the defendant-surgeon, he removed the plaintiff’s uterus without first having discussed the operation with the plaintiff or her husband. The doctor’s attorney argued that “when a patient places herself in the care of a surgeon for treatment without instructions or limitations . . . she thereby in law consents that he [the surgeon] may perform such operation as in his best judgment is proper and essential to her welfare.”

The doctor admitted that he had not obtained the consent of the plaintiff prior to the surgery, nor had he given her any indication that such an operation might be considered necessary for his patient’s best interests. The doctor inferred, instead, that implied consent had been given by the plaintiff’s husband, who had consented to the performance of a prior surgical procedure upon the plaintiff.

The appellate court rejected the paternalistic approach to the informed consent issue, stating that “under a free government . . . the free citizen’s first and greatest right, which underlies all others – the right to the inviolability of his person, in other words, his right to himself . . . necessarily forbids a physician or surgeon, however skillful or eminent, . . . to violate without permission the bodily integrity of his patient by . . . operating on him without his knowledge or consent.”

A year later, the *Pratt* case went to the Illinois Supreme Court wherein the doctor contended that since he had been given the plaintiff’s consent, and that of her husband, for the removal of the plaintiff’s ovaries in a prior surgical procedure (although the ovaries were not actually removed, and which did not alleviate the plaintiff’s complaints), consent for the subsequent removal of the plaintiff’s uterus was implied from the prior consent given for the removal of the ovaries.

The supreme court noted that there were no claims that the second surgery had been performed unskillfully, but instead that the essence of the case was that the removal of the plaintiff’s uterus was performed without her authority, or the consent of anyone competent to act on her behalf. In response to the doctor’s contention that consent for the second surgery was implied from the relationship between the parties, and from the prior history of care and treatment he had rendered to the plaintiff, the supreme court said that “where the patient is in full possession of all of his mental faculties . . . and when no emergency exists making it impractical to confer with him, it is manifest that his consent should be a prerequisite to a surgical operation.” The supreme court thereby affirmed the appellate court’s ruling, which in turn had affirmed the trial court’s finding of liability against the surgeon, and its award of damages in favor of the plaintiff.

As a corollary to the requirement of informed consent prior to treatment, the common law also recognizes the right of a patient to refuse medical care, even if the patient’s life is in jeopardy, regardless of whether the refusal of treatment is reasonable or irrational.
Generally, courts “will not inquire into the basis of a competent patient’s decision to forego a medical procedure and [to] ratify his or her decision only if it appears to be a sensible one.” Illinois has recognized the right of refusal of treatment by statute:

[A]ll persons have a fundamental right to make decisions relating to their own medical treatment, including the right to forego life-sustaining treatment.

Illinois reviewing courts have generally construed the requirement of informed consent, as well as the right of a competent patient to refuse medical or surgical treatment, rather strictly in favor of the patient’s autonomy over his or her body, rejecting notions of medical paternalism and focusing instead on the rights of the patient to self-determination over the state of his or her own health. In doing so, the Illinois appellate court has, on several occasions, reversed dismissals or summary judgments granted by trial courts in favor of physicians, based upon findings that genuine issues of material fact remained as to whether informed consent was lacking, or if the procedures performed exceeded the scope of informed consent.

A. Kenner

For example, in Kenner v. Northern Illinois Medical Center the plaintiff, an 86-year-old retired physician, entered the hospital for repair of a fractured ankle. His wife, who accompanied her husband to the hospital, signed two authorizations and consent forms on behalf of her husband, one for condition-appropriate examinations, tests and procedures, and another for the ankle surgery itself, including “such additional operations or procedures as are considered therapeutically necessary,” based upon findings made during the course of the surgery.

Four days after the surgery, the plaintiff made repeated attempts to get out of bed and to leave the hospital. Fearing injury to the plaintiff’s recently repaired ankle, the nursing staff attempted to call the plaintiff’s surgeon, but failing that, contacted another doctor who was covering the surgeon’s patients in his absence. The physician on call, who had no prior contact with the plaintiff, ordered Valium injections and the use of soft restraints on the plaintiff’s arms and legs as necessary. Both the on-call physician who had prescribed the Valium, and the surgeon who allegedly authorized its administration to the plaintiff, were sued for medical battery. The trial court granted summary judgment in favor of both physicians, holding that the scope of consent as set forth in the forms signed by the plaintiff’s wife on his behalf had either expressly or impliedly permitted the administration of Valium by the on-call physician. The appellate court reversed and remanded the case for trial, holding that “[c]onsent to medical treatment by a particular physician is normally a question of fact to be determined at trial.”

The appellate court saw nothing in the consent forms expressly authorizing treatment by the on-call physician, and likewise saw nothing implyingly consenting to his treatment since there was no evidence that the plaintiff had ever been informed, or had agreed to, the on-call arrangement whereby one doctor could cover another physician’s caseload. The treatment by the so-called “unauthorized physician” thereby created a jury question on the plaintiff’s claim of medical battery.

B. Gaskin

One year later, the Fourth District Appellate Court reversed a dismissal of a plaintiff’s claim for medical battery brought against an oral surgeon who had extracted nineteen teeth from the plaintiff’s mouth when the
extraction of only fourteen teeth had been authorized. In *Gaskin v. Goldwasser* the plaintiff, who had extensive dental problems including severe infections and periodontal disease, was referred by his dentist to the defendant, an oral surgeon, for the extraction of the affected teeth. The plaintiff initially stated that he wanted all of his remaining nineteen teeth removed, but later told the defendant that he wanted to keep five of the teeth in order to anchor a denture. Upon performing the extractions, the defendant oral surgeon noted extensive bone loss with regard to all of the plaintiff’s teeth, and that the five teeth that the plaintiff said he wanted to retain would all require root canal treatment and extensive restorative dentistry in order for any of them to be saved. The remaining teeth were therefore extracted to prevent further or continued infection.

The trial court dismissed the medical battery count that the plaintiff had filed against the oral surgeon for the removal of the five remaining teeth, finding that their removal was substantially similar to the procedure that the plaintiff had expressly authorized (*i.e.* the removal of the other fourteen teeth) and was not a deviation from the standard of care. The appellate court reversed and remanded the battery claim for trial on the basis that the removal of the remaining five teeth was “substantially at variance with the consent given,” and that when the defendant performed procedures other than those authorized, there was sufficient evidence to support liability under a theory of battery.

C. Gragg

Lastly, in *Gragg v. Calandra* the plaintiff sued the hospital and the physicians who had provided care to her father, who had been seen in the emergency room for heart problems. The patient’s wife (the plaintiff’s mother) had signed a consent form on behalf of the plaintiff’s father which authorized certain cardiac tests including catheterization and an angiogram. The plaintiff’s father suffered a cardiac arrest during the procedure and became unconscious and unresponsive. In an attempt to save the patient’s life, the doctors performed open-heart surgery without first obtaining the consent of the patient’s wife or daughter. The patient was thereafter placed on life support, but because of irreversible brain damage the patient never regained consciousness and expired eight days after the surgery. In the time between the surgery and the patient’s death, the patient’s wife and daughter made several requests to the hospital and physicians to remove the patient from life support, citing the provisions of a living will that the patient had prepared, but the medical staff refused the requests. The decedent’s daughter brought suit against the hospital and the physicians for medical battery, both for the unauthorized heart surgery and for the subsequent life support measures performed without consent. The plaintiff and her mother both contended that had they been informed about the proposed open-heart surgery that was performed after the patient’s cardiac arrest, they would have withheld consent for the surgery, as well as for the life support measures that followed. The trial court dismissed the medical battery claim against the hospital pursuant to its motion, and the plaintiff appealed. The Second District Appellate Court reversed the dismissal of the battery claim against the hospital and remanded the case for trial stating that:

Plaintiff’s Complaint alleges that [the hospital] operated on [the patient] without consent and maintained [him on life support] against the wishes expressed in his living will and against his family’s wishes. Here, the violation of a [patient’s] right to bodily and personal integrity by an unconsented-to touching is the essence of the claim for battery. By stating that the surgery and treatment were performed without consent, plaintiff has stated a claim for medical battery.

These cases are illustrative of the fact that the appellate court of Illinois has consistently interpreted the requirement of informed consent rather strictly on behalf of the patient, and has reversed summary judgments
or dismissals of claims against care providers, remanding such cases for trial, whenever disputed fact issues are found regarding the presence, absence or scope of informed consent.

II. The Emergency Exception to the Informed Consent Rule Makes its Way into Illinois Law

As physicians and surgeons continued to face issues regarding the existence and scope of informed consent (especially in instances such as those noted in the cases above where attempts were made to prevent aggravation of an injury following surgical repair; where a seemingly appropriate extension of authorized treatment was performed; or where extraordinary measures were taken in an attempt to save a patient’s life), an exception to the requirement of informed consent developed both in Illinois and elsewhere. As initially conceived, the exception applied to situations in which a genuine medical emergency exists requiring medical or surgical care to protect the patient’s health, in such circumstances where the informed consent of the patient, or someone authorized to act on the patient’s behalf, cannot be possibly or practically obtained.

In Illinois, the emergency exception to the informed consent rule has its origin in the *Pratt v. Davis* case, previously discussed.34 Although neither the Illinois appellate court nor the Illinois Supreme Court found that the facts in the *Pratt* case constituted an emergency that would justify the application of the exception, both courts discussed circumstances which would justify the rendering of medical care, or the performance of surgical treatment, without the express consent of the patient. The appellate court recognized that:

[V]arious cases . . . might be supposed of sudden and critical emergency, in which the surgeon would be held at justified in major or capital operations without express consent of the patient, [under] the principle of an implied license.35

A year later, the Illinois Supreme Court endorsed the concept of the emergency exception to the informed consent rule, stating that:

Where the patient desires or consents that an operation be performed and unexpected conditions develop or are discovered in the course of the operation, it is the duty of the surgeon, in dealing with these conditions, to act on his own discretion, making the highest use of his skill and ability to meet the exigencies which confront him, and in the nature of things he must frequently do this without consultation or conference with anyone, except, perhaps, other members of his profession who are assisting him. Emergencies arise, and when a surgeon is called it is sometimes found that some action must be taken immediately for the preservation of the life or health of the patient, where it is impractical to obtain the consent of the ailing or injured one or of anyone authorized to speak for him. In such event the surgeon may lawfully, and it is his duty to, perform such operations as good surgery demands, without such consent.36

This concept of “implied license” as discussed in *Pratt*, applicable to emergency situations in which actual consent cannot be obtained prior to treatment, evolved into the doctrine of “implied consent” which took root in Illinois common law,37 in Illinois statutes,38 and in jury instructions by which the triers of fact apply the law in medical battery trials.39
The Illinois Mental Health Code now specifically addresses the concept of “medical emergency,” and allows a physician to perform essential medical procedures without consent when a delay for the purpose of obtaining consent would endanger the life or adversely and substantially affect the health of the recipient of the care, and where the physician has made a good faith determination that such an emergency exists or that the recipient is not capable of giving informed consent.\textsuperscript{40}

Juries who serve as the triers of fact in medical battery cases are instructed that the express consent of the patient need not be obtained if before the performance of a medical or surgical procedure:

an emergency arises and treatment is required in order to protect the patient’s health, and it is impossible or impractical to obtain consent from the patient or someone authorized to consent for him.\textsuperscript{41}

Taking into account the three factors that serve as the foundation for the above-referenced jury instruction: (1) the existence of a medical emergency; (2) the need for treatment to protect the patient’s health; and (3) the impossibility or impracticality of obtaining consent, the Illinois appellate court formally recognized the modern version of the emergency exception to the informed consent rule, adding a fourth element based upon the concept of “implied consent” as set forth in the \textit{Restatement (Second) of Torts}, i.e. that there was no reason to believe that the patient would decline the treatment, given the opportunity to consent.\textsuperscript{42}

When the four factors referenced above are established, the emergency exception to the informed consent rule should provide a defense to the physician, hospital or other medical care provider who stands accused of the tort of medical battery.

It should be noted, however, that as with the appellate court’s narrow construction of the informed consent rule (which has led to a reversal of summary judgments or dismissals in favor of medical care providers where factual issues are found regarding the existence or scope of informed consent), the appellate court has likewise interpreted the emergency exception very strictly. In doing so, Illinois reviewing courts have regularly reversed summary judgments or directed verdicts that had been rendered in favor of care providers, remanding the patient’s claims of medical battery for trial whenever issues of fact are found regarding the applicability of the emergency exception defense.

\textbf{A. Curtis}

One of the appellate court decisions most frequently cited regarding the elements of the emergency exception to the informed consent rule is \textit{Curtis v. Jaskey}.\textsuperscript{43} In \textit{Curtis}, the plaintiff saw the defendant-physician for prenatal care. During the first visit the plaintiff told the doctor that she did not want an episiotomy during childbirth, and the doctor allegedly agreed to this request. On subsequent visits, the plaintiff claimed that she reminded the doctor of her request. Upon entry to the hospital for delivery of her child, the plaintiff signed a consent form, but crossed out the portion of the form dealing with consent to an episiotomy. Shortly before delivery of her child, the plaintiff began to tear, and an episiotomy was performed about two minutes prior to the birth. In a resulting suit for medical battery, the doctor denied that he agreed that under no circumstances would be perform an episiotomy, but stated instead that while he had agreed that he would try to avoid such a procedure, the decision as to whether or not an episiotomy would be performed was ultimately to be made during delivery. The plaintiff argued not only that she had never consented to an episiotomy, but that she had expressly forbidden the performance of such a procedure. The doctor asserted the emergency exception to the informed consent rule, contending that the condition that required the episiotomy constituted a medical
emergency. Based upon the testimony of an expert witness who supported the doctor’s position, the trial court agreed that an emergency existed at the time of delivery, and that it was impractical to obtain the plaintiff’s consent to the episiotomy. The trial judge therefore granted summary judgment in favor of the defendant-physician based upon the emergency exception defense.

After reciting the history of the informed consent rule, and the elements of the emergency exception to the rule, the appellate court focused on the origin of the exception in the notion of implied consent, and noted that the Restatement (Second) of Torts requires, as an essential element of implied consent, that the person performing the act must have reason to believe that the other person, if given the opportunity to do so, would consent to the act.44

The appellate court held that the Restatement of Torts imposes a limitation upon the concept of implied consent, on which the emergency exception is grounded, saying that:

If the individual has reason to believe that the other would not consent, he may not act. Given a belief that the other would not consent, it becomes impossible to imply consent from the circumstances.45

The appellate court took note of the fact that at the outset of her professional relationship with the defendant-doctor, the plaintiff-patient had expressly directed against the performance of an episiotomy, and had reminded the doctor of that directive on several subsequent visits prior to the birth of her child.

In response to the threefold assertion of the doctor that the performance of the procedure arose in the course of an emergency situation; was done in the best interests of the patient’s wellbeing; and that the failure to perform the episiotomy may have subjected the doctor to a malpractice claim, the appellate court first noted that:

the mere existence of an emergency that places a patient at risk of future harm does not give a physician ‘a license to force medical treatment and ignore a patient’s exercise of the right to refuse medical treatment.’46

As to the potential for malpractice exposure for not performing the episiotomy, the appellate court said that since actions for malpractice must be predicated upon a duty arising from the doctor-patient relationship, “a patient can delimit the scope of the relationship and thus the scope of the physician’s duty, by withholding consent to particular procedures,” adding that “an action for malpractice cannot be maintained for failure to perform a procedure that a patient has forbidden.”47

B. In re Estate of Allen

Subsequently, in the case of In re Estate of Allen,48 the Illinois appellate court set forth another comprehensive recitation of Illinois law regarding the circumstances under which the emergency exception to the informed consent rule is applicable. The court again showed how strictly the reviewing courts will examine the facts of the case to determine whether all necessary elements of the exception are present as a matter of law.

The Allen case involved a young woman who was brought to the hospital by a police officer who had arrested her for driving under the influence of drugs. Upon arriving at the hospital, she signed a consent form but did not consent to the drug screening test that the emergency room physician wanted to perform in order to determine the existence of a potentially fatal overdose or drug interaction. The patient was disorientated,
unstable and uncooperative and was alternatively somnolent and aggressive. A bottle of muscle relaxant pills which had been prescribed for the patient’s sister had been found in the patient’s car. Based upon the date of the prescription, and the number of pills left in the bottle, it was determined that the patient may have overdosed on the pills, which contained a central nervous system depressant. In addition to the suspected overdose of muscle relaxants, it was also feared that the patient may have ingested other drugs as well, based upon her symptoms. The emergency room physician determined that the patient was not competent to refuse medical treatment and ordered a forced catheterization in order to obtain a urine sample, as well as a blood draw and the administration of drugs to counteract the suspected narcotic overdose. Lab tests revealed that in addition to having taken an overdose of muscle relaxants, the patient had also ingested benzodiazepines, opiates and marijuana.49

Although the patient had not consented to the drug screening tests, the emergency room physician, fearing a possible fatal overdose or drug interaction, performed the tests without the patient’s consent, having deemed her incapable of consent. He had, however, made no effort to secure the consent of a surrogate, such as the patient’s sister for whom the muscle relaxants had been prescribed.50

The hospital where the patient was treated, as well as the emergency room physician who had ordered the forced drug screen testing and the administration of the anti-narcotic, were sued for medical battery. After considering the deposition testimony of the patient and her doctor, the trial court granted the doctor’s motion for summary judgment, holding that the significantly impaired condition of the patient, coupled with a potentially life-threatening circumstance under which she presented at the hospital’s emergency room, justified the application of the emergency exception to the informed consent rule.51

The issue on appeal was whether the emergency room doctor’s uncontroverted opinion regarding the patient’s lack of capacity to consent to medical treatment, coupled with the patient’s potentially life-threatening circumstances, justified the application of the emergency exception to the informed consent rule, so as to shield the hospital and the physician from liability for alleged medical battery.

The appellate court reviewed each of the four essential elements of the emergency exception against the facts as presented to the trial court. As to the first two elements of the exception, i.e. the existence of a genuine medical emergency and the consequent necessity of treatment, the court determined that the existence of a potentially life-threatening overdose or drug interaction, and the need to perform drug screening to determine if the patient was in peril, fully satisfied the first two elements of the emergency exception to the informed consent rule.52 Regarding the third element, however, i.e. the impossibility or impracticality of obtaining consent to the testing and treatment, either from the patient herself, or from someone authorized to consent on her behalf, the court found no genuine issue of material fact as to the patient’s own decisional incapacity, but also found that the defendants had not proven, beyond any genuine issue of material fact, that obtaining the consent of someone who could speak for the patient was either impossible or impractical.53 The record demonstrated that no search for a surrogate had been attempted, and that factor, combined with a triable issue over the fourth element of the emergency exception, i.e. whether the patient would have consented to the testing and treatment had she been capable of doing so, constituted grounds for the reversal of the summary judgment, and the remand of the case for a jury trial on the applicability of the emergency exception defense.54

C. Sekerez

Most recently, in Sekerez v. Rush University Medical Center,55 the plaintiff’s decedent, who had been diagnosed with chronic lymphocytic leukemia, a terminal cancer, was seen in the defendant’s emergency room with multiple complaints and was thereafter admitted to the hospital. He did not sign a general consent form
upon admission, although the hospital had a general consent policy acknowledging a duty to refrain from unauthorized treatment, and also recognizing a patient’s right to refuse treatment. Hospital policy provided that any procedure or treatment that posed a risk to the patient required written authorization by the patient, following an explanation to the patient of the potential risks and complications of the procedure. Verbal consent was acceptable per hospital policy, if the verbal consent was documented on the patient’s chart, but only for routine procedures that posed no risk to the patient.56

Following his admission to the hospital, the plaintiff’s decedent was diagnosed with bacterial pneumonia, and was placed in intensive care. An intern prescribed a blood thinner to prevent the development of deep vein thrombosis, a condition to which the decedent was susceptible due to his cancer and other risk factors. An hour after the first dose of the medication was administered, a nurse wrote in the patient’s chart his statement that: “I don’t need blood thinners.” The medication was then temporarily discontinued, but thereafter increased pursuant to an order of another intern due to the patient’s decreasing oxygen levels. On two occasions thereafter, the patient refused additional administration of the blood thinner. The patient thereafter became unresponsive and was intubated. He subsequently experienced a massive brain hemorrhage and expired four days after the blood thinner medication had been stopped.57

The hospital and the two interns who had ordered the administration of the blood thinner, along with a resident and the attending physician who supervised the patient’s care by the interns, were all sued for negligent treatment as well as for medical battery arising from the administration of the blood thinner to which the decedent had not consented, and which he had stated that he did not need.

The plaintiff’s medical expert testified at trial that based upon the hospital’s records and the autopsy report, the administration of four doses of blood thinner was the proximate cause of the patient’s death, although admitting that the administration of the initial dose of the blood thinner was consistent with the appropriate standard of care, given the patient’s condition. The attending physician testified at trial that despite the absence of written consent on the part of the patient for the administration of the blood thinner, it was within the standard of care to administer such medications to patients who were admitted to intensive care for an underlying condition that carried a high risk of deep vein thrombosis, were over 40 years of age, and were confined to bed. The attending physician admitted, however, that a CT scan performed upon the patient did not show any evidence of pulmonary embolism. The trial court directed a verdict in favor of all defendants on the medical battery claim, finding that there was no affirmative act on any of the physicians to support such a charge, since the initial dose of the medication comported with the standard of care and that the subsequent doses were administered in accordance with the “dosing card” guidelines based upon the decedent’s worsening respiratory condition.58

On appeal, the First District Appellate Court reversed the directed verdict on the medical battery claim and remanded the case for trial. The court based its reversal largely upon evidence of the decedent’s refusal of the medication on three occasions, and the fact that the administration of the drug carried risks to the patient that required the patient’s informed consent. The appellate court concluded that the elements of the emergency exception to the informed consent rule had not been demonstrated beyond any factual dispute, especially in light of the decedent’s persistent refusal of the medication, and the absence of any evidence of later consent on the part of the patient or members of his family for the subsequent doses of blood thinner.59
III. Conclusion

Modern American medical practice has come a long way since the days in which the American Medical Association’s first version of its Code of Ethics “advised against allowing the patient any voice in diagnosis or treatment” and instructed physicians to “unite in tenderness with firmness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence.”

Medical-legal literature is now replete with references to the shift from physician paternalism to patient self-determination in matters of care and treatment.

The cases cited in the article exemplify this shift, and demonstrate the strict interpretation that the appellate courts of Illinois have applied to the rule of informed consent, as well as the narrow construction that reviewing courts have adopted regarding the emergency exception.

(Endnotes)

1 In re Estate of Longeway (Keiner v. Community Convalescent Center), 133 Ill. 2d 33, 549 N.E.2d 292 (1989); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).

2 See Section II, infra.

3 Curtis v. Jaskey, 326 Ill. App. 3d 90, 759 N.E.2d 962 (2d Dist. 2001); Longeway, supra, 133 Ill. 2d at 44-45, 549 N.E.2d at 297.

4 “Battery” has been defined as “the unauthorized touching of the person by another.” In re Estate of Allen, 365 Ill. App. 3d 378, 385, 848 N.E.2d 202, 210 (2d Dist. 2006). “Medical battery” is defined as “(1) an intentional act on the part of the defendant; (2) a resulting offensive contact with the plaintiff's person; and (3) a lack of consent to the defendant’s conduct.” McNeil v. Brewer, 304 Ill. App. 3d 1050, 1055, 710 N.E. 2d 1285, 1289 (3rd Dist. 1999).


8 Prosser & Keaton, Torts § 9 at p.41.


10 See, e.g., Cohen v. Smith, 269 Ill. App. 3d 1087, 648 N.E.2d 329 (5th Dist. 1995), reversing a trial court’s dismissal of a medical battery claim against a male nurse who, in the course of assisting in treatment, touched the female plaintiff and observed her in a state of undress after the plaintiff had informed the hospital that her religious views prohibited her from being touched or viewed by male staff members while undressed, even for the purpose of legitimate medical treatment.

While a lack of consent to treatment can give rise to two causes of action, one based in negligence and the other in battery (see Gragg v. Calandra, 297 Ill. App. 3d 639 at 645, 696 N.E.2d 1282 at 1287 (2d Dist. 1998); Kus v. Sherman Hospital, 268 Ill. App. 3d 771 at 779, 644 N.E.2d 1214 at 1220 (2d Dist. 1995)), some courts have distinguished between cases involving a total lack of consent for the contested act, which gives rise to a claim for battery, from those involving a lack of informed consent, which gives rise to a claim for medical negligence. See Doe v. Noe, 293 Ill. App. 3d 1099, 1113, 690 N.E.2d 1012, 1021 (1st Dist. 1997), vacated on other grounds, Doe v. Noe, 303 Ill. App. 3d 139, 707 N.E.2d 588 (1st Dist. 1998). Whether the claim is based upon battery or upon medical negligence becomes important in determining whether or not 735 ILCS 5/2-622 (dealing with the requisite affidavit of merit in a healing art malpractice case) is implicated. Such affidavits are required in negligence cases based upon lack of informed consent, but not in medical battery cases. See Cohen v. Smith, 269 Ill. App. 3d 1087, 1093, 648 N.E.2d 329, 334 (5th Dist. 1995).

Cargell v. Smith, 274 Ill. App. 3d 543 at 546, 653 N.E.2d 1317 at 1319 (1st Dist. 1995); see also Roberts v. Patel, 620 F.Supp. 323 at 325 (N.D. Ill. 1985) and Mink v. Univ. of Chicago, 460 F.Supp. 713 at 716 (N.D. Ill. 1978) (opining that “[t]rue ‘informed consent’ cases [are negligence-based since they] concern the duty of the physician to inform his patient of risks inherent in the surgery or treatment to which he has consented.”). See also, W. Prosser, Law of Torts at p.165 (4th ed. 1971).

The Hon. Donald J. O’Brien, whose rulings on evidentiary issues during trial, especially those relating to the application of Illinois Supreme Court Rule 213, are particularly instructive.


Pratt v. Davis, 118 Ill. App. 161 (1st Dist. 1905), aff’d 224 Ill. 300, 79 N.E. 562 (1906).

Pratt, supra, 118 Ill. App. at 166.

Id. at p.169-70.

Id at 166.

Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).

224 Ill. at 305, 79 N.E.2d at 564.


27 164 Ill. App. 3d at 368, 517 N.E.2d at 1139.


30 166 Ill. App. 3d at 1012, 520 N.E.2d at 1095.

31 Id.


34 See Notes 17-22, infra.

35 118 Ill. App. 165-66.

36 224 Ill. at 309-10, 79 N.E. 565.


38 See e.g., 405 ILCS 5/2-111 regarding implied consent in medical or dental emergencies.

39 See Illinois Pattern Jury Instructions – Civil (IPI) 105.06 (Emergency Arising During a Procedure – Battery) and 105.07 (Emergency Arising Before a Procedure – Battery).

40 See Note 38, infra.

41 See IPI 105.07 regarding emergencies arising before a procedure; see also IPI 105.06 regarding emergencies arising during a procedure “requiring further or different treatment.”

42 See Restatement (Second) of Torts, § 892D. See also Estate of Allen, 365 Ill. App. 3d 378 at 386, 848 N.E.2d 202 at 211 (2d Dist. 2006) (regarding the fourth essential element of the emergency exception to the implied consent rule, i.e. that “there was no reason to believe that the patient would decline the treatment, given the opportunity to consent.”


44 326 Ill. App. 3d at 95, 759 N.E.2d at 966.

45 Id.

46 326 Ill. App. 3d at 96, 759 N.E.2d at 967, quoting Prairie v. Univ. of Chicago Hospitals, 298 Ill. App. 3d 316, 325-26, 698 N.E.2d 611, 618 (1st Dist. 1998).

47 Curtis, 326 Ill. App. 3d at 98, 759 N.E.2d at 968.
49 365 Ill. App. 3d at 385, 848 N.E.2d at 209.
50 Id.
51 365 Ill. App. 3d at 384, 848 N.E.2d at 210.
52 365 Ill. App. 3d at 388, 848 N.E.2d at 213.
53 365 Ill. App. 3d at 393-94, 848 N.E.2d at 217.
54 365 Ill. App. 3d at 394-95, 848 N.E.2d at 218.
56 Id. at p.3.
57 Id. at pp.4-6.
58 Id. at pp.14-15.
59 Id. at p.27.
60 American Medical Ass’n Code of Ethics (1847) art. I (1) and (4), as reprinted in American Medical Ethics Revolution: How the AMA’s Code of Ethics Has Transformed Physicians’ Relationships to Patients, Professionals and Society, at pp.324-25 (Robert B. Baker, et al. eds., (1999)).

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