Defeat the ‘sudden medical emergency’ defense
David M. Kopstein

Even in the most egregious motor vehicle cases, insurers can escape liability by arguing that the defendant suffered from a sudden and unforeseeable physical incapacity. Foil that tactic with careful discovery and analysis.

It seemed a common and clear-cut auto case: The plaintiff’s vehicle was struck from behind while lawfully stopped at a traffic signal. After collecting the medical records and bills, the plaintiff’s attorney sent a demand package to the defendant driver’s insurer, expecting a prompt settlement.

But the insurer denied that the defendant was liable, insisting that he had experienced a “sudden medical emergency.” The defendant said he had blacked out as a result of having been told an extremely funny joke by a passenger in his vehicle. He even produced a letter from his doctor, diagnosing him with a form of laughter-induced syncope.

Although the judge in this case—less easily amused than the defendant—rejected the sudden medical emergency defense, other plaintiffs have not been as fortunate. Courts in virtually every state decline to impose liability where a motor vehicle collision demonstrably results from a sudden and unforeseeable physical incapacity.

Do not accept this argument at face value. A detailed analysis of the circumstances in each auto case may reveal ways of attacking this defense. Moreover, discovery may reveal that the defendant’s sudden emergency was caused by his or her physician, who may be liable. You may also find that the sudden emergency was foreseeable to the defendant before the collision.

The basis for the sudden medical emergency defense (also known as “sudden incapacity”) lies in the absence of any negligent conduct on the part of the defendant. Some courts even consider a sudden loss of consciousness to be an “act of God.” Courts have decided, understandably, that “as between an innocent passenger and an innocent fainting driver, the former must suffer.”

That said, this defense is not necessarily an easy out for defendants. To avoid liability on the basis of a sudden medical emergency, the defendant must show several elements:

- He or she suddenly became physically incapacitated.
- The incapacity was not reasonably foreseeable.
- The incapacity rendered the defendant unable to control his or her motor vehicle. The ensuing collision was caused by a loss of control resulting from the sudden medical incapacity.

Under the law of most states, the burden of proving the elements of the defense of sudden medical incapacity rests with the defendant, as long as the plaintiff has first made out a prima facie case of negligence.

To fall within the scope of this defense, a defendant’s alleged incapacity need not include unconsciousness, as long as the incapacity is severe enough to render the defendant suddenly incapable of controlling a motor vehicle. Even a sudden sneeze or a leg cramp, if sufficiently severe, may suffice.

Courts have drawn the line, however, at mental illness. An incapacitating mental illness will not fall within the scope of the defense, no matter how sudden or how severe, provided that the driver remains conscious. This would be contrary to well-established common law principles holding mentally ill defendants civilly responsible for their actions.

A defendant need not necessarily produce medical expert testimony in support of sudden medical incapacity. This is because the issue to be determined is not so much why the defendant became incapacitated, but whether he or she did. It does appear, however, that a defendant’s own, self-serving testimony that he or she suddenly and inexplicably blacked out must be supported by at least some corroborating evidence before this defense will be allowed.

Foreseeability and timing

The most frequently litigated issues in auto cases where the defendant alleges a sudden medical incapacity are foreseeability and timing: Was the defendant on notice that he or she was at risk for sudden incapacity? Did the incapacity actually precede the collision?
Foreseeability focuses on what the defendant knew at the time he or she made the decision to operate a vehicle and whether that decision was reasonable under the circumstances. As one court put it: "It shifts the point of inquiry away from the moment of negligent driving, and causes the jury to consider the defendant’s decision to drive at all."10

The distinction between situations in which foreseeability will be determined by a judge as a matter of law and those in which it will be considered a jury question often is unclear. Obviously, the defense of sudden medical incapacity will be rejected as a matter of law where the defendant knows that he or she is subject to seizures and that the condition is not medically under control.11

In a variety of other circumstances, however, courts have been inconsistent about whether a jury question is presented. One court held, for instance, that as a matter of law a defendant’s heart attack was not foreseeable where the defendant knew only that he was suffering from long-term heart disease, where he had no particular reason to believe that an attack was imminent, and where his doctor had placed no limitation on his driving.12

In another case, a state supreme court held that a jury could find that a defendant’s fainting spell was foreseeable, even though the evidence showed only a two-month history of headaches with no previous episodes of fainting.13

Timing often must be determined entirely on the basis of circumstantial evidence. This is particularly true in cases where the parties are arguing about whether the defendant suffered a heart attack immediately before an accident or as a result of it. Where the defendant is found dead after the crash, fact testimony regarding his or her behavior just before the accident—coupled with medical testimony based on the condition and position of the defendant’s body immediately after the accident—may be considered sufficient to present a jury question regarding the timing of the defendant’s incapacity.14

A plaintiff can overcome the argument that the driver had passed out before the accident by showing that the movement of the defendant’s vehicle was not what one would expect of a car with an unconscious driver. In one case, the plaintiff prevailed because the defense was unable to explain how the defendant’s vehicle continued to travel straight forward in its own lane while the driver allegedly was unconscious.15 Similarly, in cases where the defendant survives, testimony that he or she appeared to be entirely alert and unimpaired immediately after an accident can be used to rebut the defense.

**Physician liability**

Your inquiry should not end there. Recent case law suggests additional questions that must be explored when confronting the defense of sudden medical incapacity. For instance, was the defendant driver’s incapacity caused by a medication? If so, was the drug administered, provided, or prescribed by a physician who can be held liable for failing to warn the defendant of the risk that he or she might become incapacitated while driving?

Until recently, courts uniformly rejected attempts to impose liability on physicians for negligence resulting in injuries to third parties in car accidents. Some courts held that, as a matter of law, a physician cannot be held liable to third parties because he or she owes no duty to anyone outside the physician-patient relationship.16 Courts have based their refusal to impose such a duty on the physician’s presumed inability to control the patient’s conduct.17

But judicial attitudes toward cases like this are changing. In the past decade, courts have been more willing to impose liability on health care providers who indirectly injure third parties through motor vehicle accidents caused by their impaired patients. As a result, the longstanding principle that a physician owes no duty to a nonpatient has been significantly eroded.

One of the first such cases was Cram v. Howell—and, as one might expect, it involved truly egregious circumstances.18 In Cram, the plaintiff’s decedent died from injuries he sustained in a motor vehicle accident that occurred when the other driver became unconscious as a result of vaccines administered by that driver’s physician.

The plaintiff alleged that the physician was well aware of the vaccines’ tendency to produce unconsciousness: The patient had experienced two episodes of loss of consciousness in the physician’s office before being allowed to drive away. Nevertheless, the trial judge dismissed the complaint for failing to state a viable cause of action against the physician.
The Indiana Supreme Court distinguished earlier case law, which had refused to recognize any duty running from a physician to a nonpatient. Using an appropriate metaphor, the court said that its earlier holding "should not be interpreted as inoculating physicians so as to give them complete immunity against third-person claims."19

Given the physician’s awareness of the danger and the fact that the alleged negligence (the failure to appropriately monitor the patient and warn him not to drive) did not in any way invade the physician-patient relationship, the court found that it was entirely appropriate to recognize a duty running from the physician to the plaintiff’s decedent.

In 2002, the Hawaii Supreme Court reached a similar conclusion in McKenzie v. Hawaii Permanente Medical Group.20 The plaintiff in the case had been struck and injured by a motor vehicle that was operated by a driver who had a reaction to a medication that had been negligently prescribed.

The court recognized a duty running from the physician to the accident victim, but it carefully limited that duty. The court found that the physician could be held liable to the plaintiff for having failed to adequately warn the driver about the effects of the medication, which was a controlled substance.

The court specifically declined to extend that duty to noncontrolled medications, however. It also declined to extend that duty to the physician’s decision to administer the medication in the first place or to his determination of the appropriate dosage. The court reasoned that it would be contrary to public policy to require physicians to consider the interests of nonpatients in deciding how to treat a patient.

The Tennessee Supreme Court took a similar position in Burroughs v. Magee.21 There, the court held that a physician could be held liable to third parties injured in a car accident caused by a patient to whom the physician had prescribed a medication that impaired the patient’s driving ability.

As in McKenzie, however, this duty to third parties did not extend to the physician’s decision to prescribe the medication in the first place. Instead, the court limited the duty to one obligating the physician to warn the patient of the possible adverse effects of the medication on his or her ability to operate a motor vehicle.

More recently, the Massachusetts Supreme Judicial Court adopted the same rule in Coomes v. Florio, a case that has been highly publicized.22 In that case, a cancer patient who had been negligently advised by his physician that he could resume driving lost consciousness behind the wheel and killed the plaintiff’s 10-year-old son.

A divided court held that the physician could be held liable to third parties at least for having failed to warn his patient of the effects of treatment, finding it unnecessary to decide whether such liability could be based on the treatment itself. The court specifically rejected the defendant’s argument that imposing liability under these circumstances would lead to an increase in medical malpractice insurance rates, stating that the legislature, not the court, must address such concerns.

Some courts have recognized an even broader duty running from physicians to nonpatients affected by their negligence. In Taylor v. Smith, the Alabama Supreme Court went beyond Burroughs and McKenzie and held that a physician could be held liable for negligently prescribing methadone to a known drug abuser, who then got into a motor vehicle accident, injuring the plaintiff.23 The court also held that such a cause of action was not subject to the state’s medical malpractice act.

The willingness of courts to hold physicians liable for harm to third parties is even greater where the harm was highly foreseeable. In Hardee v. Bio-Medical Applications of South Carolina, Inc., that state’s supreme court imposed liability on a dialysis center for a nonpatient’s injury arising from a motor vehicle collision with a patient.24

The court based its decision on the center’s failure to warn the patient of the risks of driving after dialysis. The court reasoned that because such a duty to warn already existed in favor of the patient, it was appropriate to recognize a cause of action in favor of nonpatients who are foreseeably harmed by the breach of that duty.

Thus far, courts have not allowed nonpatient plaintiffs in auto cases to sue others, in addition to prescribing physicians, who may have indirectly caused the tort. For instance, Maryland’s highest court recently rejected an attempt by a plaintiff to impose liability on a drug manufacturer, where a nonpatient died in a motor vehicle accident resulting from the driver’s prescription-drug-related loss of consciousness.25

Eschewing the reasoning of other states’ appellate courts, which found a duty of physicians to nonpatients, the Maryland court rejected the notion that a duty arises in
favor of any class of people to whom harm is foreseeable. Here, the court said, the nexus between the defendant’s alleged negligence and the plaintiff’s injury was insufficient to warrant the imposition of a duty to the plaintiff.

Despite some adverse court rulings, at no time should the defense of a sudden medical emergency be an insurmountable obstacle in auto cases. Examine the timing, foreseeability, and circumstances of the alleged emergency in meticulous detail—doing so will allow you to find additional evidence that will help you defeat this defense.

And in cases where the emergency is related to a medication, be sure to explore the possibility of bringing in the defendant’s physician as an additional defendant.

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Notes:
8. Storjohn, 519 N.W.2d at 528.
11. Storjohn, 519 N.W.2d at 528-29.
12. See e.g. van der Hout v. Johnson, 446 P.2d 99 (Or. 1968). The fact that a defendant has been cleared by his or her physician to drive, however, is not necessarily persuasive. See e.g. Freese v. Lemmon, 267 N.W.2d 680 (Iowa 1978).
13. See e.g. Keener v. Trippe, 222 So. 2d 685 (Miss. 1969).
19. Id. at 1097.
20. 47 P.3d 1209 (Haw. 2002).
22. 877 N.E. 2d 567 (Mass. 2007); see George Annas, Doctors, Drugs, and Driving: Tort Liability for Patient-Caused Accidents, 359 New Eng. J. Med. 521 (July 31, 2008).
23. 892 So. 2d 887 (Ala. 2004).