
Informed Consent in Illinois

Harold L. Jacobson

Follow this and additional works at: <https://via.library.depaul.edu/law-review>

Recommended Citation

Harold L. Jacobson, *Informed Consent in Illinois*, 18 DePaul L. Rev. 458 (1969)

Available at: <https://via.library.depaul.edu/law-review/vol18/iss2/7>

This Article is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Law Review by an authorized editor of Via Sapientiae. For more information, please contact wsullivan6@depaul.edu, c.mcclure@depaul.edu.

INFORMED CONSENT IN ILLINOIS?

HAROLD L. JACOBSON*

THE band wagon for informed consent began rolling about twenty years ago. Some states have climbed aboard, others have heard the drums but are just beginning to face the music, and the band wagon has not yet reached others. It remains to be seen whether the courts which have not been called upon to express their opinions as to the validity of informed consent will reject or accept the theory. Up to this time the courts of Illinois have not been confronted with the choice.

The term "informed consent" has arisen to describe a theory in medical malpractice which allows a cause of action to a person who consents to medical treatment without first having been adequately informed as to the nature and consequences of the attendant risks. Although informed consent does not pertain to negligence in the prescribing of treatment, or in the actual treatment rendered by the physician, there does seem to be general agreement that the theory of informed consent sounds in negligence rather than in assault and battery.¹

In *Natanson v. Kline*,² a frequently cited opinion, the court, distin-

* MR. JACOBSON is a partner in the firm of Lord, Bissell and Brook of Chicago, Illinois. He is also an instructor at the Lawyers Institute in Chicago, Illinois. He received an LL.B. from Loyola University Law School.

¹ See Note, *Physician's Duty to Warn of Possible Adverse Results of Proposed Treatment Depends Upon General Practice Followed by Medical Profession in the Community*, 75 HARV. L. REV. 1445 (1962); Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967).

² *Natanson v. Kline*, 186 Kan. 393, 401-02, 350 P.2d 1093, 1100-01 (1960), *rehearing denied*, 187 Kan. 186, 354 P.2d 670 (1960):

"What appears to distinguish the case of the unauthorized surgery or treatment from traditional assault and battery cases is the fact that in almost all of the cases the physician is acting in relatively good faith for the benefit of the patient. While it is true that in some cases the results are not in fact beneficial to a patient, the courts have repeatedly stated that doctors are not insurers. The traditional assault and battery involves a defendant who is acting for the most part out of malice or in a manner generally considered as 'antisocial.' One who commits an assault and battery is not seeking to confer any benefit upon the one assaulted. The fundamental distinction between assault and battery on the one hand, and negligence such as would constitute malpractice, on the other, is that the former is intentional and the latter unintentional. *Hershey v. Peake*, 115 Kan. 562; 223 P. 1113 (1924); and *Maddox v. Neptune*, 175 Kan. 465; 264 P.2d 1073 (1953). We are here concerned with a case where the patient consented to the treatment, but alleged in a malpractice action that the nature and consequences of the risks of the treatment were not properly explained to her. This relates directly to

guishing between an assault and battery and a negligent act of malpractice, held that the doctrine of informed consent sounds in negligence. However, confusion as to the nature of the theory, as one of battery or negligence, is evidenced in the opinions of some courts which have attempted to apply the doctrine.³

As indicated in *Natanson*, the doctrine of informed consent concerns the question of whether or not the nature and consequences of the proposed operation or treatment have been adequately explained to the patient. One of the first judicial statements describing this duty appeared in *Salgo v. Leland Stanford Jr. University Board of Trustees*,⁴ in which the court labored with the legal and nonlegal difficulties confronting the doctor in determining just what should be told to a patient concerning his treatment.

To determine whether Illinois would adopt such a doctrine, we must first look to the basis of the duty to disclose to the patient the nature and consequences of a proposed treatment or operation. As stated in *Natanson v. Kline*:

The courts frequently state that the relation between the physician and his patient is a fiduciary one, and therefore the physician has an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness.⁵

the question whether the physician has obtained the informed consent of the patient to render the treatment administered."

³ See, e.g., *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1966); *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966).

⁴ 154 Cal. App. 2d 560, 578, 317 P.2d 170, 180-81 (1st Dist. 1957):

"A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent. See *Hunt v. Bradshaw*, 242 N.C. 517; 88 S.E.2d. 762 (1955). Cf. *Simone v. Sabo*, 37 Cal. 2d 253; 231 P.2d 19 (1951); *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92; 52 UL.R.A., N.S. 55 (1914)."

⁵ *Natanson v. Kline*, *supra* note 2, at 403, 350 P.2d at 1101.

The "fiduciary relationship" between physician and patient has been recognized in Illinois in a different context,⁶ where the question arose as to whether a contract between physician and patient could be presumed fraudulent. It seems to be a logical step to extend this fiduciary relationship to the duty to disclose. No court has ever denied that there is a fiduciary relationship between physician and patient which requires disclosure under normal circumstances. Nor does it seem that an Illinois court would be justified in denying that, in general, *some* duty to disclose exists. The belief that each person's body is inviolable has historic roots in Anglo-American law.⁷ In light of this belief, it seems reasonable to require that a physician disclose to the patient the nature and consequences of the proposed treatment or operation so that the patient himself can make an "intelligent decision" as to whether the physician should proceed as proposed. Thus, it would appear that Illinois courts, like the courts of all the other states that have considered this problem, may well hold that such a general duty of disclosure exists.

There is greater diversity of opinion as to the specifics of the duty to disclose. This diversity is most frequently displayed on the issue of whether the plaintiff must present expert testimony as to a standard of disclosure (*i.e.*, whose standards of proper conduct are to be applied in this area, the medical profession's or the jury's?).

Everyone is aware of the imperative need for the wrongfully injured party's case to reach the jury. Plaintiffs feel that malpractice cases are not receiving their share of jury determinations. Those advocating more jury determinations in malpractice cases believe that the defendant can adequately argue the law to the jury under a given set of facts. They further believe that depriving a plaintiff of jury determination by the court's directing a verdict discriminates against the injured plaintiff in this type of case as opposed to certain kinds of other tort cases. They seem content that a jury can satisfactorily determine these complicated and technical medical questions without regard to their lack of medical training. Most of those courts which have considered the problem state the standard of disclosure as being what a reasonable medical practitioner would disclose regarding the nature and consequences of the proposed treatment or operation under the same or similar circum-

⁶ See *Zeigler v. Illinois Trust and Savings Bank*, 245 Ill. 180, 196-97, 91 N.E. 1041, 1047 (1910).

⁷ See *Sibbach v. Wilson & Co., Inc.*, U.S. 1, 17 (1941) (Frankfurter, J., dissent); *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

stances. Use of such a standard will almost invariably result in requiring that the plaintiff establish the standard of disclosure in a particular case by expert medical testimony. The states that have adopted this general rule as to the requirement of expert testimony are: Delaware, Florida, Iowa, Kansas, Michigan, Minnesota, Missouri, New Jersey, South Dakota, Texas, Washington and Wyoming.⁸ In addition, it appears, though it is not completely clear, that this general rule has been adopted in New York and Tennessee.⁹ However, there are a few cases holding contrary, and some law review articles suggest that there should be no requirement of expert medical testimony as to the standard of disclosure.¹⁰ States where cases have been reported holding that expert testimony is not a requisite part of plaintiff's case are New York, Missouri and Minnesota.¹¹

The New York case of *Fiorentino v. Wenger*¹² held that the defendant physician, the only physician in the county employing a certain surgical procedure, was obligated to disclose that the procedure proposed was novel and unorthodox and that there were risks incident to its use. There is no indication in the opinion of the appellate court that there was any expert medical testimony; indeed, it would appear impossible for anyone other than defendant himself to testify as an expert since he was the only physician using the procedure. In the absence of a standard in the medical community, it was necessary for the court to use its own standard. This does not necessarily mean that there is no requirement of expert medical testimony under ordinary circumstances. On appeal the New York Court of Appeals stated:

[I]t is perhaps the most delicate matter, often with fluctuating indications, from

⁸ Delaware: *DiFillippo v. Preston*, 53 Del. 550, 173 A.2d 333 (1961); Florida: *Ditlow v. Kaplan*, 181 So.2d 226 (Fla. App. 1965); Iowa: *Grosjean v. Spencer*, 258 Iowa 685, 140 N.W.2d 139 (1966); Kansas: *Collins v. Meeker*, 198 Kan. 390, 424 P.2d 488 (1967); Michigan: *Roberts v. Young*, 369 Mich. 133, 119 N.W.2d 627 (1963); Minnesota: *Ericksen v. Wilson*, 266 Minn. 401, 123 N.W.2d 687 (1963); Missouri: *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); New Jersey: *Kaplan v. Haines*, 96 N.J. Super. 242, 232 A.2d 840 (1967); South Dakota: *Bloch v. McVay*, 80 S.D. 469, 126 N.W.2d 808 (1964); Texas: *Wilson v. Scott*, 412 S.W.2d 299 (1967); and Wyoming: *Govin v. Hunter*, 374 P.2d 421 (Wyo. 1963).

⁹ *Fiorentino v. Wenger*, 19 N.Y. 2d 407, 227 N.E.2d 296 (1967); *Ball v. Mallinkrodt Chemical Works*, 53 Tenn. App. 218, 381 S.W.2d 563, 19 A.L.R.3d 813 (1964).

¹⁰ See *supra* note 1.

¹¹ New York: *Fiorentino v. Wenger*, 26 App. Div. 2d 693, 272 N.Y.S.2d 557 (1966), *rev'd on other grounds*, 19 N.Y.2d 407, 227 N.E.2d 296 (1967); Missouri: *Mitchell v. Robinson*, 334 S.W.2d 11 (Mo. 1960); and Minnesota: *Bang v. Charles T. Miller Hosp.*, 251 Minn. 427, 88 N.W.2d 186 (1958).

¹² *Supra* note 9.

time to time with the same patient, whether a physician should advise the patient (or his family), more or less, about a proposed procedure, the gruesome details, and the available alternatives. Such a decision is particularly one calling for the *exercise of medical judgment*.¹³

Thus, it would seem that the rule in New York is that expert testimony is required in order to establish the standard of disclosure.

The rule in *Natanson v. Kline*, discussed above, has been limited to its facts by subsequent cases.¹⁴ In *Natanson*, there was no disclosure of any collateral risk by the physician. The subsequent Kansas cases¹⁵ hold that expert medical testimony is required, except when the physician has made absolutely no disclosure. These cases recognize that the physician's silence does not preclude him from showing that his silence complied with medical standards under the circumstances.¹⁶ No other courts have expressed an opinion as to the wisdom of this modification of the rule requiring expert testimony; however, it appears that the Kansas rule is a historical accident resulting from the Kansas court's unwillingness to overrule *Natanson v. Kline*. There does not appear to be any convincing reason why the silence of a physician should be treated differently if the silence fulfills the reasonable medical standard, unless the situation is so unusual as to make it reasonable for a jury to conclude that the failure to disclose is *prima facie* evidence of negligence. However, in *Collins v. Meeker*,¹⁷ the Kansas court held that *res ipsa loquitur* was not applicable in medical malpractice actions. This seems to indicate that there is no logical basis, other than an attempt by the law to create a minimum standard, for this exception to the rule requiring medical testimony to establish the standard of disclosure.

The Missouri court, however, was not as reluctant to correct its earlier mistake. In *Mitchell v. Robinson*,¹⁸ the court held that expert testimony was not required to prove a *prima facie* case. *Aiken v. Clary*¹⁹ overruled *Mitchell*, holding that the plaintiff, in order to sus-

¹³ *Supra* note 9, at 415, 227 N.E.2d at 300 (emphasis added).

¹⁴ *Collins v. Meeker*, *supra* note 8; *Williams v. Menehan*, 191 Kan. 6, 379 P.2d 292 (1963).

¹⁵ *Collins v. Meeker*, *supra* note 8; *Williams v. Menehan*, *supra* note 14.

¹⁶ *Collins v. Meeker*, *supra* note 8, at 398, 424 P.2d at 495.

¹⁷ *Supra* note 8.

¹⁸ *Supra* note 11.

¹⁹ *Supra* note 8.

tain his burden of proof, must offer expert testimony to show what disclosures a reasonable medical practitioner would have made under the same or similar circumstances.

*Bang v. Charles T. Miller Hospital*²⁰ presents a situation in which the requirement of expert medical testimony can legitimately be dispensed with. In *Bang*, plaintiff submitted to a prostate operation, a necessary part of which involved the severance and tying off of the spermatic cords. At issue was whether the physician had disclosed to the patient the fact that sterilization would accompany the operation. The court held that this was a question for a jury and that no expert testimony was needed to establish whether or not the physician should have disclosed the unavoidable result of sterility. The court held the physician had such a duty as a matter of law where no immediate emergency existed and the patient had a choice of going without treatment which might prove injurious, or undergoing a treatment which would necessarily make him sterile. The *Bang* case was later distinguished in *Ericksen v. Wilson*,²¹ wherein the Minnesota rule requiring expert testimony was enunciated. The point of distinction between *Bang* and *Ericksen* is that in *Bang* a procedure was used which involved a touching (the cutting of the spermatic cord) to which the patient did not consent, whereas in *Ericksen* there was no unconsented touching, but rather the complaint was based upon a failure to disclose collateral risks. Thus, the Minnesota court characterized the *Bang* case as involving a battery. A distinction more consistent with the above statement can be found in *Roberts v. Young*:

The case of *Bang v. Charles T. Miller Hospital* . . . is not in point for the reason that there a result, serious in nature, was certain to happen, whereas in the case at bar there was a mere possibility.²²

This basis for distinguishing *Bang* from the usual case involving a failure to disclose risks seems reasonable. When a result is certain to occur (*i.e.*, in *Bang*, sterility), it seems reasonable for the law to establish this minimum standard of disclosure for which no expert testimony is needed, since the certainty of the result eliminates some of the judgment factors necessary in deciding what the standard of disclosure should be. Thus, there appears to be no strong authority

²⁰ *Supra* note 11.

²¹ *Supra* note 8.

²² *Supra* note 8, at 140, 119 N.W.2d at 630.

in the case law for dispensing with expert medical testimony in deciding what the proper standard of disclosure is.

This does not mean that the controversy as to the necessity of expert testimony has subsided. The particular fact situation presented in this type of case has produced judicial opinions which leave room for comment by those theorists and scholars interested in lessening the plaintiff's burden in the medical malpractice suit. Some have contended that the standard of disclosure is not a medical one, and therefore, expert medical testimony is not needed to establish the standard.²³ Some of the arguments supporting this view are as follows: (1) A question of fact as to the reasonableness of the doctor's conduct is presented if the doctor has not fulfilled his duty to disclose, thus allowing the jury to determine whether or not the doctor acted reasonably without the need of expert medical testimony, just as the jury decides whether a tortfeasor in other areas of tort law has acted reasonably or not. (2) In those instances where there is no community standard, there is no validity to the requirement of expert medical testimony to show what that expert would do under like circumstances. (3) The burden on the plaintiff to obtain expert medical testimony in most, if not all, malpractice cases is unfair because of the reluctance of such witnesses to appear in court and criticize their professional brethren.

Some theorists have advocated changing the standard of disclosure to be imposed upon the physician.²⁴ One such standard suggested has the effect of shifting the burden of proof to the physician, requiring him to prove the reasonableness of his actions. The plaintiff need not introduce expert medical testimony to present a prima facie case, though the defense may use expert testimony in its behalf. The plaintiff then has the right of cross-examination as well as possibly calling the defendant as an adverse witness.

The main criticism of the majority standard is that there is in reality no community medical standard to be followed which designates what risks should be disclosed. Yet, expert witnesses have been testifying as to the standard of disclosure.²⁵ The expert testimony

²³ See *supra* note 1.

²⁴ See Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967).

²⁵ Woods v. Pommering, *supra* note 8; Gray v. Grunnagle, *supra* note 3; Wilson v. Scott, *supra* note 8; Kaplan v. Haines, *supra* note 8; Anderson v. Hooker, 420 S.W.2d 235 (Tex. Civ. App. 1967).

in these cases casts doubt on the argument that no standard exists. While it can be argued that the testimony consists only of personal opinions of what good medical procedure is, this is not what the expert witnesses purport to be testifying about.

The criticism may be advanced that the requirement of expert testimony to establish the standard of disclosure allows the medical profession to define its own legal standards of conduct. In response to just such a criticism of the general requirement of expert testimony in malpractice cases, Prosser has recognized the judicial reluctance to overburden the doctor with liability which is imposed by uneducated judgment.²⁶

With respect to the criticism of the majority standard, based upon the fact that plaintiffs often experience difficulty in obtaining expert witnesses, defense attorneys, who have had their share of losses, do not believe this is the problem that plaintiffs pretend to make of it. It may be true that due to the uncertainty in the practice of medicine, practitioners are less likely to speculate on mere possibilities just to formulate a fact question. There is more than lip service paid to the doctrine that a mistake in judgment is not negligence. However, this author does not know of any case of real malpractice that was defeated as a sole result of the unavailability of an expert witness.

It perhaps serves a purpose to look at the cases collectively which have held that expert testimony is not a requirement. Judicially recognized exceptions to the rule requiring expert testimony have not involved the question of whether the physician adequately disclosed the collateral risks or hazards in the proposed treatment (excepting the Kansas rule which dispenses with the requirement of expert testimony when the plaintiff's case shows that the physician made absolutely no disclosure as to possible risks). The cases in which no expert testimony was required have involved: (1) a situation where the physician failed to inform the patient of a disability that was certain to result from the proposed operation which was not an emergency requirement;²⁷ (2) a situation where the physician removed the patient's breast after obtaining her consent to a mastectomy without explaining its meaning and the patient clearly made known to the physician that he was just to make a test of the breast and was not to remove it;²⁸ (3) a situa-

²⁶ PROSSER, TORTS § 32, at 168 (3d ed. 1964).

²⁷ *Bang v. Charles T. Miller Hosp.*, *supra* note 11.

²⁸ *Corn v. French*, 71 Nev. 280, 289 P.2d 173 (1955).

tion where the proposed operation or treatment is so novel that a standard of the medical community could not have been developed;²⁹ (4) a situation where the physician has knowingly given untrue answers to the questions of the patient where none of the exceptions to the rule requiring candor and disclosure apply.³⁰ The first situation appears to fall within the minority holding eliminating the need for expert testimony. In the latter three situations, dispensing with the requirement of expert medical testimony seems reasonable, as a jury can reasonably and intelligently consider such acts of the physician to be unreasonable and negligent. Indeed, confusion arises in that these cases could have been based on theories other than informed consent.

In most cases involving the informed consent theory, the duty imposed by law is to inform the patient of those possible risks or hazards involved in the proposed treatment or operation that a reasonable medical practitioner would disclose under the same or similar circumstances. Hence, the majority of states take the view that this standard of disclosure is medical, and therefore, expert testimony becomes necessary.

Occasionally, a court has held that the physician was under no duty to disclose the collateral risks and hazards. These decisions usually are based on the fact that the risks are minimal and disclosure seems unreasonable. For instance, it has been held that anesthesiologists need not disclose the risks involved in the use of a certain anesthetic where the risks are minimal.³¹ Anesthesiologists have also been held not to have the duty to disclose because it would be unreasonable to impose a duty of disclosure on each specialist involved in each specific step of an operation.³² Possibly underlying these rulings is the feeling that the general public recognizes that there are certain risks involved in the use of any anesthetic.

Even if the plaintiff establishes by expert testimony that the standard of disclosure of the medical community had not been satisfied by the warnings made by the defendant physician, the physician still may assert the defense that the failure to disclose was justified by the physician's concern about the patient. It would seem that the

²⁹ Fiorentino v. Wenger, *supra* note 9.

³⁰ Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962).

³¹ Gravis v. Physicians & Surgeons Hosp., 415 S.W.2d 674 (Tex. Civ. App. 1967).

³² Bell v. Umstattd, 401 S.W.2d 306 (Tex. Civ. App. 1966).

plaintiff's experts could not testify on this subject without knowing the basis for the defendant's position. Therefore, the plaintiff's experts would probably have to testify as to the objective standard of disclosure of the medical community. Several cases that have considered this question have held that the burden is on the defendant physician to show the disclosure would have only disturbed the patient emotionally.³³ However, in *Aiken v. Clary*,³⁴ the court stated that the plaintiff's expert witness would have to consider these subjective factors in testifying.

A troublesome factual issue on which expert testimony is not necessary relates to whether the physician actually made the proper disclosure. If plaintiff testifies that the physician did not disclose the risk which resulted in injury to him, and plaintiff presents evidence that good medical practice requires disclosure of that risk, then a jury question is created. The assertion of the defendant physician that he made the proper disclosure does not take the case away from the jury, for the issue is the credibility of the parties, an issue which the jury traditionally decides.

On the issue of proximate causation, there has also been some disagreement in the cases. The burden of proof on this issue is on the plaintiff.³⁵ Plaintiff must show that if he had been fully advised as to the collateral risk (which resulted in his injury), he would not have submitted to the operation or treatment.³⁶ There could be no proximate causation, of course, if the patient knew of the risk which was not

³³ *Ball v. Mallinkrodt Chemical Works*, *supra* note 9. *Contra*, *Woods v. Brumlop*, *supra* note 30.

³⁴ *Aiken v. Clary*, *supra* note 8, at 674:

"The question is not what, regarding the risks involved, the juror would relate to the patient under the same or similar circumstances, or even what a reasonable man would relate, but what a reasonable medical practitioner would do. Such practitioner would consider the state of the patient's health, the condition of his heart and nervous system, his mental state, and would take into account, among other things, whether the risks involved were remote possibilities or something which occurred with some sort of frequency or regularity. This determination involves medical judgment as to whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy, no matter how expertly performed. [Defendant in this case testified that plaintiff was 'real shook.'] After a consideration of these and other proper factors, a reasonable medical practitioner, under some circumstances, would make full disclosure of all risks which had any reasonable likelihood of occurring, but in others the facts and circumstances would dictate a guarded or limited disclosure. In some cases the judgment would be less difficult than in others, but, in any event, it would be a medical judgment."

³⁵ See *Shetter v. Rochelle*, *supra* note 3.

³⁶ *Plante, An Analysis of "Informed Consent,"* 36 *FORDHAM L. REV.* 639, 641 (1968).

disclosed by the physician. The causal connection here can most often be proved by plaintiff's testimony that he would not have consented to the operation or treatment if he had known of the risks. Then, unless the assertion is inherently incredible because of the slight injury involved, a jury question is presented. One court has held that the plaintiff's testimony is not necessary,³⁷ and contrariwise the North Carolina court has required proof of causation other than plaintiff's testimony.³⁸ However, the North Carolina court does not seem to have maintained that position, since *Sharpe v. Pugh*,³⁹ wherein it held that the plaintiff's allegations in his complaint that he would not have submitted to the treatment had he known the risks, were sufficient to defeat a motion to strike. Thus, it appears that in most cases the plaintiff's testimony on the issue of proximate causation would be sufficient, and, in some states, unnecessary if the other facts of the plaintiff's case permit the jury to draw an inference that the plaintiff would not have given his consent had he been properly informed.

A subsidiary issue may be raised by criticism of the difficulty experienced by plaintiffs in obtaining expert medical testimony. In some states, plaintiffs have been able to solve this problem by calling the defendant physician and eliciting the necessary expert testimony from him. This procedure is exemplified in *Wilson v. Scott*,⁴⁰ wherein the plaintiff called the defendant as an adverse witness. The defendant testified as to the standard of disclosure and that his statements to the plaintiff satisfied these standards. Plaintiff testified that the warnings given by defendant did not satisfy these standards. The court held that a question of fact was presented by this conflict in testimony. It is unclear whether such a practice would be permitted in Illinois. While Section 60 of the Illinois Civil Practice Act would permit a plaintiff to call the adverse party as a witness, it says nothing about the calling of the adverse party to provide expert testimony. Section 60 is based on Section 33 of the Act relating to the Municipal Court of Chicago which in turn was derived from the Minnesota code. Thus, Minnesota decisions are very high authority in construing the statute. The Minnesota Supreme Court has held that the plaintiff could not

³⁷ *Aiken v. Clary*, *supra* note 8.

³⁸ *Watson v. Clutts*, 262 N.C. 153, 160-61, 136 S.E.2d 617, 622 (1964).

³⁹ *Sharpe v. Pugh*, 270 N.C. 598, 155 S.E.2d 108 (1967).

⁴⁰ *Supra* note 8.

attempt to make the defendant his expert medical witness.⁴¹ Thus, it would appear that such a practice would be improper under Illinois law.

CONCLUSION

I tend to feel that our courts will have to look hard at this doctrine of informed consent. In view of the liberal tendencies prevailing at this time, it may be anticipated that our state might well adopt the doctrine. To hope that the need for such a doctrine will be found wanting seems unrealistic in this age where the ways a plaintiff may recover money damages are ever expanding.

It is hoped that if Illinois courts recognize this doctrine, it will be on the basis of another form of negligence. The majority view of the negligence aspect of this doctrine has undoubtedly been influenced by the practical and evidentiary problems presented to the other courts. To preserve sound medical practice and keep evidentiary rules in the field of malpractice consistent, it is hoped our courts would treat informed consent on a negligence basis.

Acceptance of the doctrine of informed consent presumes that the doctor owes the patient a duty to disclose reasonably anticipated consequences of treatment, or perhaps the lack thereof, which a reasonable medical practitioner would disclose under like or similar circumstances. It seems reasonable to assume that if the courts of Illinois adopt the doctrine, they will follow the almost unanimous rule requiring expert medical testimony to establish the risks of which the patient should be informed. By requiring the use of expert testimony, Illinois would also promote harmony between informed consent and the standards of conduct used in all medical practice cases in this state arising out of other forms of alleged error. As in other negligence cases, the burden of proof is on the plaintiff. It is difficult to conceive that society as a whole would benefit by permitting lay determination of an essentially medical problem. Medical treatment should continue to be consistent with good medical practice rather than what may be reasonable to the butcher, the baker, and the candlestick maker.

Proximate cause is a necessary ingredient in a negligence action.

⁴¹ *Ericksen v. Wilson*, *supra* note 8. *But see Piacentini v. Bonnefil*, 69 Ill. App. 2d 433, 217 N.E.2d 507 (1966).

Emasculation of this element of plaintiff's proof is not to be anticipated. There appears to be no justifiable reason to eliminate it. In the simple case, if need be, plaintiff can personally supply the necessary testimony.

Finally, without going into detail or lengthy discussion, it is this author's expectation that our courts will not permit the plaintiff to call a defendant under adverse examination and require him to give expert testimony against himself.