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The Doctor as Witness: Statements for Purposes of Medical Diagnosis or Treatment

WILLIAM H. THEIS*

INTRODUCTION

The evidentiary rules on statements made for purposes of medical diagnosis or treatment have great importance in the trial of personal injury cases.¹ The typical factual setting, in broad outline, is easily stated. The injured plaintiff visits a doctor and describes his aches, pains, and suffering. He may make statements to the doctor about the cause of his troubles. If called to testify at trial, the doctor may be asked to repeat the patient’s assertions. These statements may often constitute hearsay and will be inadmissible unless an exception to the hearsay rule is found.

This article examines the present state of Illinois law governing the admissibility of such statements. Treatment of this issue under Federal Rule of Evidence 803(4) is explored as an alternative permitting broader admissibility. Finally, the impact of adopting the federal approach, as would have occurred under the proposed Illinois Rules of Evidence, is assessed.

GENERAL DOCTRINAL DEVELOPMENT

The Rationale for the Hearsay Rule

The Illinois law can best be understood by considering the general development of the doctrine admitting statements made by an injured declarant.² Initially, the common law admitted, as an exception to the hearsay rule, spontaneous expressions of pain and suffering³ without regard to whom the declarant made his statement. The courts emphasized two considerations. A spontaneous statement of pain and suffering, even as related by someone other than the injured person, offered the best evidence of the suffering and its true character. The afflicted person’s reconstruction in a courtroom of

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1. These rules are also applicable in the criminal context. See People v. Ward, 61 Ill. 2d 559, 205 N.E.2d 425 (1975); People v. Gant, 58 Ill. 2d 178, 317 N.E.2d 564 (1977). However, the issue is more likely to arise in tort litigation.


his past suffering often provided a poor substitute for statements made while he felt the injury. In these cases, "necessity" formed a basis for admissibility. Moreover, being spontaneous and contemporary with the pain, the statements were considered to have greater probative value. A spontaneous statement, which by definition implies a lack of premeditation, gave some indication of trustworthiness. It was common, therefore, for the courts to admit such statements as part of the res gestae.

Statements to physicians might be just as spontaneous as statements to witnesses of an injury in the sense that the declarant, wracked with pain, will still blurt out the truth with no dissembling. Such statements, however, might be less spontaneous in the sense that they occur some time after injury and, more importantly, in response to searching questions by the doctor. As this ambiguity in the meaning of "spontaneous" became apparent, the decisions down-played the necessity principle and emphasized the trustworthiness of such statements. In doing so, the opinions also changed the focus of "trustworthiness." The patient's desire for effective treatment, and not the immediacy of the statement, became the guarantor of trustworthiness.

Illinois, like many other jurisdictions, admits testimony of a treating physician which relates the patient's out-of-court statements of his condition, symptoms, and suffering. The development of the rationale supporting this exception to the hearsay rule has followed the general doctrinal pattern. The Illinois Supreme Court, when first deciding the issue in 1867, approved a physician's testimony relating the patient's statement of bodily condition "[I]f said under circumstances which free [the patient's statement] from all suspicion of being spoken with reference to future litigation, and give it the character of res gestae." By 1954, the court's emphasis

4. Wigmore (3d ed.), supra note 2, §§1714, 1718, at 57-60, 63-64.
6. McCormick's modern statement of the rationale is typical:
Although statements to physicians are not likely to be spontaneous, since they are usually made in response to questions, their reliability is assured by the likelihood that the patient believes that the effectiveness of the treatment he receives may depend largely upon the accuracy of the information he provides the physician.

had changed: "[I]t is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid."

The courts consider an individual seeking treatment likely to make truthful statements regarding his condition because he wants the doctor's best-informed judgment as to the course of treatment he should undergo. This policy basis for the exception, although widely invoked and usually unquestioned, is open to inquiry and criticism. The rule assumes a patient who suffers genuine illness. More importantly, it assumes the patient has minimal ability to reject the advised course of treatment. If the patient suffers from no illness at all, however, he may either reject the treatment, sometimes without informing his physician, or may follow the treatment, as long as he has a reasonable expectation that the treatment will have no deleterious effects. For example, a patient complaining of "whiplash" has little to lose by so representing to his doctor. If the doctor prescribes pain-killers and a cervical collar, the patient might easily disregard the treatment without ever informing his doctor. He might choose to follow the treatment with little danger to his actual good health.

It is impossible to determine which stereotype is predominant: the patient who makes truthful disclosure for fear that his health will be further endangered if he misleads his doctor or the patient who manufactures symptoms, secure that he can do himself no harm. The law has assumed the honest patient in accepting these statements for the truth of the matter asserted.

In actual practice, this assumption may make little difference to the outcome of the case. The patient will usually have given his own testimony as to the matters related to the doctor and is himself subject to cross-examination. The facts in a given case may raise the jurors' suspicions that the patient gave his doctor false information. Furthermore, the doctor's testimony is also subject to cross-examination, which may establish that the doctor is relating the patient's statements without vouching for their truthfulness. It is, therefore, unlikely that the false statement will go undetected in the majority of cases.

When the patient is unavailable at trial, usually because of his death, this exception to the hearsay rule may present the potential for significant impact on the outcome. In this situation, the doctor's testimony may well be the only competent evidence as to the truth of the matters contained in the patient's statement. In spite of the

reduced opportunity to ascertain the patient's veracity, the rationale behind the exception leads to admissibility.

No reported Illinois case has raised the issue of whether the doctor's testimony as to pain and suffering need be corroborated. The Illinois courts long rejected any testimony by the doctor as to causation of injuries. The application of this rule often arose in situations where the doctor's testimony would have been uncorroborated, if admitted. The easing of this rule has occurred in cases where the doctor's testimony has been corroborated. Although corroboration has not been explicitly required, it might be rash to discount the necessity of corroborative evidence.

DISTINCTIONS BASED ON THE SUBSTANCE OF THE STATEMENT

Statements of Present and Past Pain

Reliance on the patient's desire for effective treatment as the basis for the hearsay exception does not limit the physician to only those symptoms which bothered the patient at the time the statement was made. The patient's complaint of prior pain and suffering may also be admissible since both present and past pain could form the basis for diagnosis and treatment.

It has been observed that statements of past pain should be excluded as less trustworthy because they are more capable of simulation. This position places too much emphasis on the patient's suffering as the only guarantee of truthfulness. Spontaneity, in the sense of an unpremeditated response occasioned by pain, may be a necessary indication of truthfulness in some situations, but it is not crucial to the doctor-patient relationship. If it is assumed that a patient seeks treatment for present ailments which may have also troubled him in the past, a full and complete history will be taken and relied upon by his treating physician. The trustworthiness problems posed by admitting statements under these circumstances are minimal.

Much more difficult to deal with is the patient claiming only past pain and no present symptoms. If the patient claims to seek a tardy treatment for past ailments in fear that they may re-occur, his statements should be no less admissible, although perhaps more suspect. The patient who suffers no present pain or symptoms may be seeking an expert witness and not actual treatment. As long as he seeks

10. See notes 14-16 infra and accompanying text.
12. This relationship is often non-spontaneous in the sense already noted. See text accompanying note 6 supra.
treatment, however, the same presumption of truthfulness should prevail.

The Illinois courts do not recognize a distinction between past and present pain. Physicians may testify about the patient's statements of both kinds of suffering. 13

Statements of Causation

Whether the treating physician may relate the patient's statements about the cause of his injuries is the most troublesome aspect of the hearsay exception. For years, the Illinois courts adhered rigidly 14 to the traditional and widely recognized rule 15 that such statements may not be admitted into evidence.

The original rationale for the exception partially explains this rigidity. A patient's statement as to causation does not satisfy the necessity principle. For this issue, his spontaneous statements during his suffering would be no more complete nor helpful than his direct testimony at trial. Pain is more difficult to reconstruct and relate than causation. If his injuries should result in death, his legal representative has a very real "need" for the deceased's out-of-court statements, but the necessity principle operated in the more narrow sense already noted.

"Spontaneity" provides a less satisfactory explanation for the traditional inadmissibility of causal statements. The statement of cause and effect was evidently regarded as perhaps too large an endeavor for an individual making "spontaneous" statements while he was wracked with pain. The suspicion of falsification was perhaps stronger when the causation issue was involved. Whether in-

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14. In one case for recovery of accidental death insurance benefits, the deceased patient was himself a doctor. The court's ruling of inadmissibility should give some idea of the fervor with which Illinois courts have enforced the "causation" qualification to the hearsay exception. See Globe Accident Ins. Co. v. Gerisch, 163 Ill. 625, 45 N.E. 563 (1896).


The first Illinois case to recognize the treating physician exception to the hearsay rule nonetheless ruled inadmissible the doctor's account of the patient's statement that his injuries were caused by the defendant's conduct. Illinois Cent. Ry. v. Sutton, 42 Ill. 438 (1867).
jured persons are less "spontaneous" in their statements of causation than in their statements of pain and suffering is an impossible judgment to make, except on the basis of hunch. The suspicion may be justified because the causation issue is often more difficult to prove than the damages issue, especially when the declarant has died and there is no corroboration of the doctor's proposed testimony.

The Illinois Supreme Court, in a 1954 decision frequently noted by commentators,\(^\text{17}\) seemingly broke from its rigid position. In *Shell Oil Co. v. Industrial Commission*,\(^\text{18}\) a claimant for workmen's compensation asserted that he injured his back when he fell in the course of his employment. Although the opinion does not specifically state, presumably the claimant, who was injured but not killed, testified to the facts underlying his claim. His doctor was allowed to testify to the patient's statement of these facts made during treatment. The court stated in allowing this testimony:

> declarations of an injured person to his treating physician as to his physical condition, and the cause thereof are admitted in evidence for the reason that it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid.\(^\text{19}\)

The court relied on the modern guarantee of trustworthiness, the patient's desire for treatment, and ignored the more traditional bases for the exception. In this casual manner, the court turned its back on numerous decisions to the contrary, not even acknowledging the major change it may have wrought.

Testimony as to causation has been upheld in one other supreme court case.\(^\text{20}\) In *People v. Gant*,\(^\text{21}\) an assault victim refused to testify at trial because she did not want to harm the defendant, her boyfriend. Her doctor, however, was allowed to state that she had told him that she had been struck on the head by a shotgun and that the gun discharged. She further told her doctor that she knew her attacker, although she did not name him. The doctor testified that he had asked her about the causation of her wound in order to have a "better understanding" of her problem. He had been previously


\(^{18}\) 2 Ill. 2d 690, 119 N.E.2d 224 (1954).

\(^{19}\) Id. at 602, 119 N.E.2d at 231 (emphasis added).


\(^{21}\) 58 Ill. 2d 178, 317 N.E.2d 564 (1974).
told that she had received a gunshot wound but, from his own examination, had diagnosed a blow from a blunt instrument.

The court's opinion is unclear, but the doctor's statement was evidently offered to prove that the victim had been unlawfully struck and that, inferentially, the defendant performed the unlawful act. If the court admitted the statement for this purpose, it went well beyond the current trend to admit statements concerning causation. The modern view stresses that statements "fixing fault" may not be received.22

The decision raises additional questions because it seems to focus on the importance which the doctor attributes to such information, not on the importance which the patient might reasonably think that the doctor attributes to such information. Perhaps the doctor's asking a question regarding this issue serves to validate the court's judgment that a patient would answer truthfully in order to obtain effective treatment. Whether objective relevance or relevance reasonably perceived by the patient controls admissibility is a question yet to be resolved. The modern development of the position on non-causative statements has always focused on the patient's perceptions; it is likely that development of doctrine on causative statements will follow the same pattern.

Even if the premise that patients truthfully relate symptoms because they desire effective treatment is accepted, it is more difficult to accept that they consider statements as to causation of equal importance for receiving adequate care. It is even less likely that they would consider the identity of the causative factor to have any relationship to proper treatment. In Gant, for example, the victim could falsely assert that Gant had hit her with the shotgun and not fear that this lie to her doctor would affect her treatment. In Shell Oil, if the claimant had fallen and injured his back when working on his plumbing in the basement, a statement that he fell on the job is a lie with no penalty arising out of the treatment process. The identity of the causative factor is relevant only to the litigation; who caused the assault is the key to a criminal prosecution, and where the accident occurred is the key to workmen's compensation litigation. For this reason, hearsay statements of a general causative nature could be admissible since they may relate to treatment; statements as to particular identity should not be admitted through the exception.

In both Gant and Shell Oil, the physician's testimony was corro-

bated on the issues to which the statements were related. It re-

mains to be seen whether the Illinois courts would allow a treating
physician’s testimony to stand as sole support on an issue of causa-
tion, especially with regard to identity. To read Shell Oil broadly
as allowing uncorroborated statements by physicians as to causa-
tion is premature.

Even if courts are willing to accept statements as to causation,
some discrimination in the choice of “causal” facts should be exer-
cised. Illinois Central Railroad v. Sutton illustrates that the patient
may not be in a position to attribute causation authoritatively. The
defendant’s agents wrongfully ejected plaintiff from a train,
which necessitated his walking a mile or two to the nearest station.
At trial, his doctor testified that the patient told him that this walk
aggravated a pre-existing illness. The doctor gave no opinion of his
own as to causation. In reversing, the supreme court noted that
while the facts might support a jury verdict as to causation, the
plaintiff could not render an opinion on causation and transmit it
through his doctor.

DISTINCTIONS BASED ON STATUS OF THE WITNESS

Using the patient’s desire for effective treatment as support for
the hearsay exception also raises questions of who may testify con-
cerning the patient’s statements. The rationale explains the Illinois
courts’ willingness to extend the exception beyond medical doctors
to osteopathic doctors. How far Illinois extends the rule beyond the
common law exception of doctors and interns is not clear. Consis-
tent with the rationale, however, statements to anyone the patient
might reasonably think is in a position to treat his illness or to assist
in that treatment should be admissible.

While the treating physician is clearly within the exception, the
examining physician, under Illinois law, may not relate what the

23. 42 Ill. 438 (1867). See also W. King & D. Pillinger, A STUDY OF THE LAW OF OPINION
EVIDENCE IN ILLINOIS 95 (1942).
25. An intern was not permitted to relate the patient’s statements in Chicago Packing Co.
A chiropractor has been allowed to testify, Voight v. Industrial Comm’n, 297 Ill. 109, 130
N.E. 470 (1921), as have nurses, Hammer v. Slive, 35 Ill. App. 2d 447, 183 N.E.2d 49 (1962);
2d 425, 248 N.E.2d 96 (1969), indicates that a clinical psychologist would also be able to so
testify.
26. See, e.g., Shaughnessy v. Holt, 236 Ill. 485, 86 N.E. 256 (1908); Greinke v. Chicago
City Ry., 234 Ill. 564, 85 N.E. 327 (1908); Chicago Union Traction Co. v. Giese, 229 Ill. 260,
82 N.E. 232 (1907); Chicago & E.I.R.R. v. Donworth, 203 Ill. 192, 67 N.E. 797 (1903); West
patient has told him. The appropriate test for separating these two breeds of doctor, therefore, assumes no small importance in personal injury litigation.

The rationale for admitting the treating doctor's testimony suggests the rationale for excluding the testimony of an examining doctor. If the patient is presumed to tell the truth when he wants effective treatment, the law should assume no similar reliability when the patient is describing his illness to a doctor from whom he does not seek treatment. When the patient seeks an expert for purposes of testifying, he seeks only to better his legal position; he not only lacks the motivation to be truthful, but he actually has a motivation to be untruthful. Of course, even the neophyte lawyer could develop these probabilities through cross-examination and argument; however, the traditional view regards such testimony as too dangerous to be admissible. 27

The rationale also provides a general guideline for the identification of the examining physician: characterization and admissibility should properly rest on the actual expectation of the patient that he will receive treatment from the doctor whose testimony counsel later seeks to elicit. 28

Unfortunately, the Illinois cases provide little helpful guidance on the actual test used. The opinions all too often merely state that a doctor falls into one or the other class and assigns the predictable consequences to that characterization. 29 The remaining cases typically provide negative guidelines rather than comprehensive criteria. For example, a doctor need not prescribe treatment to be considered a treating physician. 30 If he does, the patient's failure to follow the advice given will not change the characterization. 31 A doctor is not an examining physician merely because he spoke with

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the patient after suit was filed;\textsuperscript{32} neither does one become a treating physician merely because he spoke with the patient before suit was filed.\textsuperscript{33}

Two significant questions of characterization are apparent. To what extent do the doctor’s expectations about, or understanding of, his role affect his status? One opinion hints that if the doctor regards himself as an examining physician then the court will so regard him.\textsuperscript{34} Ultimately, the test should center around the patient’s expectations because it is the patient’s expectations which determine his statements. If on this foundation fact, however, the doctor’s expectation is uncontradicted by the patient, the doctor’s state of mind should support a finding that he is an examining physician.\textsuperscript{35}

The more difficult question is whether a doctor must be exclusively a treating or an examining physician. Could he perform both functions? How should the law treat his testimony if he does so? The cases seem to adopt the rule that an examining doctor is one whose sole function is to examine;\textsuperscript{36} a treating doctor may both treat the patient and examine him with a view to trial. In many cases, this analysis can be supported because treatment and examination are integrally related.

It is a hypothetical case that raises the analytical difficulty. Assume that the doctor provides treatment. At some later date, the patient returns, not for treatment but for examination with a view toward trial. Since the patient expects no treatment, it could be argued that statements made at this later time do not satisfy the trustworthiness test. On the other hand, the treating doctor’s familiarity with the patient’s actual symptoms may deter the patient from making untruthful statements at the examination prior to trial. While the doctor’s familiarity may guarantee some truthfulness, the argument against admissibility is not satisfied. Particularly where the symptoms are of a subjective nature, the patient, in an effort to secure favorable testimony, may be able to feign injuries that have healed since treatment ended.

\textsuperscript{34} Casey v. Chicago City Ry., 237 Ill. 140, 86 N.E. 606 (1908).
The Illinois decisions are split on this issue although the weight of authority favors admissibility. While apparently accepting the proposition that a patient might still hope for effective treatment resulting even from an examination on the eve of trial, the decisions leave open the possibility that the length of time between consultations for treatment and those for examination might influence the outcome.\(^7\)

Unlike the treating physician, the examining doctor's testimony is limited to objective conditions observed during his examination. He may not relate the patient's physical manifestations of symptoms or the patient's conduct if this activity is capable of being feigned by the patient.\(^8\) The patient's statements, as subjective conduct, are similarly treated. The patient's ability to affect the examination through his behavior, even though the doctor feels qualified to detect "cheaters," renders the results inadmissible.\(^3\)

\textit{Dickeson v. Baltimore & O.C.T.R.R.}\(^4\) emphasizes that the objectivity of the test controls admissibility of the examining physician's testimony. To rebut a defense of contributory negligence in a personal injury case, the minor plaintiff asserted his subnormal intelligence, offering the testimony of a psychologist that, based on tests given the plaintiff, the boy had a sub-normal IQ. The defendant objected to an opinion based upon test responses which the plaintiff might have formulated in a calculated effort to aid his case. The court admitted the evidence on the foundation testimony that the tests were objective. The witness' assertion that the tests were objective laid a sufficient foundation. That the tests, not the witness, could detect falsification was crucial.\(^4\)

Closely analyzed, \textit{Dickeson} raised the two issues most prevalent

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40. 42 Ill. 2d 103, 245 N.E.2d 762 (1969).

to the limitations on examining doctor testimony. Whether the test results as subjective data might be admissible notwithstanding a hearsay objection is the first issue. Whether the expert can base his opinion on those results even if they are inadmissible is the second. Traditionally, the Illinois cases merged the two issues. Unlike some other jurisdictions, Illinois did not permit the examining physician to relate subjective symptoms or statements even for the non-hearsay purpose of explaining the basis for his expert opinion. Expert opinion could be given in two forms. An answer could be based on objective data collected by him. An opinion could also be an answer to a hypothetical question based on facts properly in evidence.

In a recent Illinois case, People v. Ward, the supreme court changed its position on the second issue raised by Dickeson. This may signal a change on the first issue. The court approved one psychiatrist's partially basing his opinion of the defendant's sanity on the expert medical opinion of another psychiatrist. Although the other doctor's report had been admitted into evidence at the defendant's urging, the court stated that the witness could have permissi-

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42. See McCormick (2d ed.), supra note 6, at §293.
43. Knowledge of subjective symptoms, alone, was not enough to disqualify the examining physician where the opinion was itself based on objective symptoms. Jensen v. Elgin, J. & E. Ry., 24 Ill. 2d 383, 183 N.E.2d 211 (1962); Emerton v. Canal Barge Co., 70 Ill. App. 2d 49, 216 N.E.2d 457 (1966).

Even if admitted, the opinion of an examining physician based on subjective symptoms might constitute harmless error for the reason that independent evidence supported similar statements related by the examining physician. See Hastings v. Abernathy Taxi Ass'n, 16 Ill. App. 3d 671, 306 N.E.2d 498 (1973); Korleski v. Needham, 77 Ill. App. 2d 328, 222 N.E.2d 334 (1966).

See generally W. King & D. Pillinger, A STUDY OF THE LAW OF OPINION EVIDENCE IN ILLINOIS 98-104 (1942).
44. Objective data is information that is not within the patient's option as to whether he is candid with the doctor. An X-ray is an example of objective data. See, e.g., Greinke v. Chicago City Ry., 234 Ill. 564, 85 N.E. 327 (1908); Chicago City Ry. v. Shreve, 226 Ill. 530, 80 N.E. 1049 (1907).

Objective symptoms are those which the physician discovers by examining the patient; subjective symptoms are those which he learns from what the patient tells him. Reflexes of the knee or foot, Hirsch v. Chicago Consol. Traction Co., 146 Ill. App. 501 (1909), increased pulse rate, Schmidt v. Chicago City Ry., 239 Ill. 494, 88 N.E. 275 (1909), and loss of head rotation, Backlund v. Thomas, 40 Ill. App. 2d 8, 189 N.E.2d 682 (1963), have been held to be objective symptoms. Inability to flex finger muscles, Baines v. Chicago City Ry., 147 Ill. App. 601 (1909), and twitching of the hand, Wells Bros. Constr. v. Industrial Comm'n, 306 Ill. 191, 137 N.E. 791 (1922), have been held to be subjective symptoms because the response was within the patient's control by exercise of voluntary muscles.
45. See People v. Hester, 39 Ill. 2d 489, 237 N.E.2d 466 (1968); Crane Co. v. Industrial Comm'n, 32 Ill. 2d 348, 205 N.E.2d 425 (1965).
bly stated an opinion based, in part, on the other doctor's opinion even if the latter had not been admitted into evidence. Relying on the reasoning behind Federal Rule of Evidence 703, the court noted that since experts rely on such data in forming their opinions during the course of diagnosing patients, they may base their testimony on this same kind of data. The further development clearly contemplated in the federal rules has been approved in later cases: in order to disclose the basis of his opinion, the expert may relate the out-of-court statements of the other experts.

No case has yet approved an opinion based upon the statements of the patient to the examining physician. But the potential for this development is clear. If statements by the patient are "reasonably relied upon by experts . . . in forming opinions," then the doctor or any expert should be able to state his opinion and state the basis of his opinion. Obviously this extension of Ward would greatly erode the rule that the examining physician may not relate subjective symptoms. It is doubtful that the doctor's testimony will be so limited if Ward is extended beyond an expert's reliance on other experts.

The Federal Rules of Evidence allow statements of the patient to

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47. In People v. Ward, 61 Ill. 2d 559, 567-68, 338 N.E.2d 171, 176-77 (1975), the court adopted the particular statement in the Advisory Committee Notes to Federal Rule 703:

A third source contemplated by the rule consists of presentation of data to the expert outside of court and other than by his own perception. In this respect the rule is designed to broaden the basis for expert opinions beyond that current in many jurisdictions and to bring the judicial practice into line with the practice of the experts themselves when not in court. Thus a physician in his own practice bases his diagnosis on information from numerous sources and of considerable variety, including statements by patients and relatives, reports and opinions from nurses, technicians and other doctors, hospital records, and X-rays. Most of them are admissible in evidence, but only with the expenditure of substantial time in producing and examining various authenticating witnesses. The physician makes life-and-death decisions in reliance upon them. His validation, expertly performed and subject to cross-examination, ought to suffice for judicial purposes.


48. FED. R. EVID. 705.


50. The cases in note 49, supra, although involving statements made in part by the patient, are examples in which his statements were admissions and therefore not technically hearsay. FED. R. EVID. 801 (d)(2)(A). So far no case has involved a "self-serving" statement.

51. FED. R. EVID. 703:

The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to him at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.
be related by the examining physician for the truth of the matter stated.\textsuperscript{52} This step is rationalized by the perceived inability of the jury to adequately compartmentalize the permitted uses of statements of the patient.\textsuperscript{53} If the Illinois courts look to the Federal Rules of Evidence for guidance, their approval of the expert opinion may also lead to admission of the patient's statement as substantive evidence.

**THE ALTERNATIVE PRESENTED BY FEDERAL RULE 803(4)**

The proposed Illinois Rules of Evidence recommended the adoption of a hearsay exception identical in language to Federal Rule 803(4).\textsuperscript{54} If accepted, the proposal would clarify and modify current Illinois law concerning statements made for purposes of medical diagnosis and treatment.

Prior Illinois law has admitted statements made by persons other than the injured party where the statements were made for purposes of diagnosis and treatment.\textsuperscript{55} Arguably, these instances could be limited on the facts to parents speaking on behalf of infant children. The federal rule implies no such limitation. This broader formulation allows greater flexibility; however, the courts may read at least one restraint, a close relationship between the declarant and the injured party, in order to assure the trustworthiness of the statement.

The proposed rule also extended the exception to statements other than those made to doctors.\textsuperscript{56} As long as the declarant is attempting to obtain treatment or diagnosis, statements to any person to whom he speaks in this effort are admissible. Adoption of this approach could clear up the present uncertainty on this point in Illinois without sacrificing the necessary indicia of reliability.\textsuperscript{57}

Illinois law presently allows the treating physician to relate the patient's statements as to the causation of his injuries. The federal rule specifically allows this practice. Indeed, the Advisory Commit-

\textsuperscript{52} See note 54 infra for text of Federal Rule 803(4).
\textsuperscript{53} \textit{Fed. R. Evid. 803(4)}, Advisory Comm. Notes.
\textsuperscript{54} \textit{Fed. R. Evid. 803(4)}:

Statements of purposes of medical diagnosis or treatment.—Statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment.

\textsuperscript{56} \textit{Fed. R. Evid. 803(4)}, Advisory Comm. Notes.
\textsuperscript{57} See text following note 9 supra.
tee's Note to Federal Rule 803(4) relies on the Illinois court's decision in Shell Oil as an example of the "current trend" embodied in the rule. The federal rule and the Illinois proposal do not define the scope of admissible statements pertaining to causation. The federal Advisory Committee Note gives an example of the rule's operation: the doctor might relate the patient's statement that he was struck by an automobile, but not that the automobile had driven through a red light and struck him. As far as it goes, the federal rule is consistent with the Illinois policy set down in Shell Oil and Gant. The example does not deal with a difficult question: may the doctor relate the patient's statement that defendant's automobile struck him? In some instances, to name an instrumentality also names the defendant. As the auto example illustrates, a statement of causation need not tell the whole story. The rule's language limits admissibility to those statements describing "the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment." It is not clear whether the "reasonably pertinent" standard is viewed from that of the doctor's need to know or the patient's expectation. While the latter view would be consistent with the rationale underlying the rule, either perspective would exclude statements pertaining to the identity of the causative factor. Certainly, the doctor does not need to know that the defendant's automobile caused the injuries in order to prescribe treatment. The patient would also know that identity of the actor or ownership of the instrumentality has no relationship to effective treatment. Clarification of this point in any future reconsideration of the rule would, however, be beneficial.

The most significant change resulting from adopting a rule like Federal Rule 803(4) would be the elimination of the distinction between treating and non-treating doctors. Indeed, the Illinois Supreme Court Committee on the Rules of Evidence directed its com-

60. This writer questions whether the rules of evidence should be fashioned with regard to whether the jury can honestly apply one rule as opposed to another. If jurors cannot be trusted, one obvious alternative, in the area under discussion, is to rule out opinion testimony by the examining physician unless he relies on objective data or speaks in answer to a hypothetical question. See text accompanying notes 44 and 45 supra. Of course, this approach has met much criticism, McCormick, (2d ed.), supra note 6, § 293, at 694, and its rejection in the Federal Rules of Evidence was understandable. But the more general observation is that juror incompetence or dishonesty is a two-edged sword in the formulation of rules of evidence. See Bruton v. United States, 391 U.S. 123 (1968), overruling Delli Paoli v. United States, 352 U.S. 232 (1957).
ment on this hearsay exception solely to this distinction. Rule 803(4) is acceptable and perhaps not even controversial if corroboration of the out-of-court statements and demonstration of subjective symptoms related by the doctor is required.

Rule 803(4)'s liberal treatment of examining physician's testimony rests on the justification that, in federal courts under Rule 703, a doctor could relate the declarant's statements in order to explain the basis for his diagnosis. Because the jury was thought to be unable to make the distinction between using the statements for the permitted purpose and using them for the truth of the matter asserted, the federal approach elected to admit the statements for all purposes. The rationale for 803(4) does not rest directly on considerations of trustworthiness. If Rule 803(4) is so linked to Rule 703, then the rationale behind Rule 703 becomes important to establishing the rationale for substantive use of the statements.

The Advisory Committee Notes to Rule 703 advance two considerations for allowing the expert to give an opinion based on facts not admitted or admissible: the facts would be typically admissible, but only after much time was taken to meet "technical" objections; and the expert, typically a doctor, makes "life-and-death" decisions based on such facts. The first factor implies that the expert must be more than a conduit for the party's case. On important factual issues, there must be corroboration for the statements related by the doctor. The Advisory Committee Note to Federal Rule 703 indicates that such evidence as hospital records and statements by other hospital personnel are often admissible anyway and that, accordingly, the doctor should have latitude to present these facts as the basis of his opinion. The Note in no way suggests that the expert should be the sole witness for the facts on which he relies. To the extent that Rule 703 contemplates corroboration or the availability of corroborative material, it does not represent, in combination with Rule 803(4), a substantial change.

The present state of Illinois law, if unchanged, and the proposed Illinois Rules of Evidence place even more emphasis on corroboration. While it may be assumed that inclusion of Rule 703 in the proposed codification implies assent to the use of subjective statements as foundation for opinion, Rule 803(6) of the proposed evi-

61. PROPOSED ILL. R. EVID. 803(4), Committee Comments (Final Draft).
62. See note 51, supra. See also text accompanying note 47, supra.
64. FED. RULE EVID. 703, Advisory Comm. Notes.
65. Id.
dence code specifically excluded medical records as an exception to the hearsay rule. Under Rule 703, the doctor could have relied on such records and even referred to the parts upon which he placed reliance, but in-court corroboration would have been required. It would serve no purpose to exclude a trained nurse’s recorded observations during treatment unless in-court corroboration is deemed advisable.

In theory, if the statement related by the doctor is admissible as a hearsay exception, the finder of fact may consider it for the truth of the matter asserted, not merely as an explanation of the expert’s premises. Even though statements may be considered in this manner, it is still theoretically possible that a special rule of corroboration might be invoked.

Weinstein and Berger suggest that the examining physician’s testimony relating the injured party’s statements might be admissible, but that a verdict based solely upon such testimony as to a material issue might not stand, particularly if the declarant is available. Even this last limitation seems ill-advised. If the examining physician’s testimony is admitted, not because of the trustworthiness of the statements related, but because the jury cannot compartmentalize, it is appropriate to require corroboration even when the declarant is unavailable.

One recent federal case indicates that the courts may interpret Rule 803(4) to authorize the doctor to serve as a conduit. The defendant, charged with kidnapping, raised the defense of insanity. His psychiatrists testified at length, relying on their interviews with the

66. Hospital records were excluded from Rule 803(6)(B) of the proposed evidence code, which continues the rule precluding admissibility established by Illinois Supreme Court Rule 236(B), ILL. REV. STAT. ch. 110A, §236(B) (1977).

PROPOSED ILL. R. EVID. 803(6):

(6) Records of regularly conducted activity. (A) Any writing or record, whether in the form of an entry in a book or otherwise, made as a memorandum, record or data compilation of any act, transaction, occurrence, or event, shall be admissible as evidence of the act, transaction, occurrence, or event, if made in the regular course of any business, and if it was the regular course of the business to make such a memorandum, record or data compilation at the time of such act, transaction, occurrence, or event or within a reasonable time thereafter. All other circumstances of the making of the writing record [sic], including lack of personal knowledge by the extrant [sic] or maker, may be shown to affect its weight, but shall not affect admissibility. (B) This rule does not apply to the introduction into evidence of medical records or police investigative reports.

Proposed Rule 803(9), Public Records, also excludes medical records from admissibility under that exception. PROPOSED ILL. R. EVID. 803(9) (Final Draft).

67. 4 J. WEINSTEIN & M. BERGER, WEINSTEIN’S EVIDENCE §803(4)[01], at 803-125 to 126, citing Aetna Life Ins. Co. v Quinley, 87 F.2d 732, 733-34 (8th Cir. 1937).

accused. Under Rule 803(4), the court approved admission of the statements made by defendant to his psychiatrists. All of the factual data leading to the doctors' opinions was admissible, but none of it was corroborated since the defendant himself did not testify. Advisory Committee Notes aside, the language of the rule is broad enough to make the expert a conduit for substantive admissibility in all cases, as long as he is an expert and the facts are those reasonably pertinent to diagnosis or treatment. Only later cases will reveal whether corroborations will be required.

If the Illinois courts were to require corroborations as a condition of admitting the patient's statements through an examining physician, then adoption of Federal Rule 803(4) would not substantially change present practice. Objective facts necessary to constitute corroborations would already be admissible, as would statements made to treating physicians. Theoretically, the finder of fact could find the examining doctor's testimony not only corroborated by other facts, but also corroborations of those other facts since his testimony is admitted for the truth of the matters stated. The fact finder, however, may tend to discount the statements brought in through the examining physician because of the inherent skepticism involved in a pre-trial, non-treating examination. From this standpoint, the proposed rule would make little practical difference.

CONCLUSION

Illinois has already adopted part of the rationale supporting Federal Rule 803(4). The approval of the rule itself through codification would serve the salutary purpose of clarifying Illinois law regarding statements made for purposes of diagnosis or treatment. The ambiguities surrounding statements of causation would be lessened, and these concerns could be eliminated with regard to the specific issue of identity. Admissibility of statements made by those other than the injured party or to those other than the doctor, where connected to diagnosis or treatment, would place more facts before the jury without jeopardizing the trustworthiness needed to support substantive use. Abolition of the treating doctor/non-treating doctor dichotomy would serve the same purpose. Upon reconsideration of the proposed rules, delineation of necessary corroborative facts, or the decision to forego corroborations, would complete the reform.

69. Given the special nature of the insanity defense, the case may have no effect outside that area. Constitutional justifications may also limit its impact to the criminal area.
70. See text following note 58 supra.