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THEODORE R. LeBLANG*

INTRODUCTION

Today the automobile has become indispensable in the lives of most Americans. The license to drive, whether it be a right or a privilege, is a valuable and necessary possession, the loss of which may lead to significantly diminished earnings, unemployment or other hardship with a consequent increase in the individual's feeling of being different. Despite this consideration, it is clear that persons suffering from poorly controlled epileptic seizure activity constitute a hazard to themselves and to others when driving an automobile.

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1. The question of whether motor vehicle licensure is a right or a privilege seems largely to have been resolved in favor of the latter conclusion. Judicial reference to motor vehicle licensure as a privilege is common in Illinois and in most jurisdictions. See, e.g., People v. Turner, 64 Ill. 2d 183, 354 N.E.2d 897 (1976); People v. Papproth, 56 Ill. App. 3d 683, 371 N.E.2d 1097 (1977); State v. Page, 332 So.2d 427, 430 (La. 1976); Ames v. Motor Vehicles Division, 16 Or. App. 288, 517 P.2d 1216 (1974); State v. Chiles, 129 Ga. App. 645, 200 S.E.2d 501 (1973); Randels v. Schaffner, 485 S.W.2d 1 (Mo. 1972); Albright v. State Department of Motor Vehicles, 81 Wash. 2d 609, 503 P.2d 739 (1972); Jicha v. Karns, 39 Wis. 2d 676, 159 N.W.2d 691 (1968); Fiske v. England, 243 A.2d 682 (D.C. App. Ct. 1968). There are, however, case examples that conclude that motor vehicle licensure is something more than a privilege and some courts have expressly found it to be a right. See, e.g., State v. Severino, 56 Haw. 378, 537 P.2d 1187 (1975); State v. Bowles, 113 N.H. 571, 311 A.2d 300, 302 (1973). Other courts have either used the terms right and privilege interchangeably, e.g., Commonwealth v. Irwin, 345 Pa. 504, 29 A.2d 68, 69 (1942), or have found driver licensure to be an interest or property right. In Tolbert v. McGriff, 343 F. Supp. 682, 685 (N.D. Ala. 1976), the plaintiff's driver's license was suspended because of periods of episodic unconsciousness. In addressing the propriety of the suspension, the court ruled that "the interest of the holder of a driver's license in keeping that license is one that is protected by due process," citing Bell v. Burson, 402 U.S. 535 (1971). In People v. Rodriguez, 80 Misc. 2d 1060, 1062, 364 N.Y.S.2d 786, 788 (1975), it was held that an operator's license is regarded as property and hence the requirements of due process are applicable. See also Reese, The Legal Nature of a Driver's License (1965).

2. Epilepsy or the epilepsies may be defined as paroxysmal transient disturbances of brain function that may be manifested as episodic impairment or loss of consciousness, abnormal motor phenomena, psychic or sensory disturbances or perturbation of the autonomic nervous system. Symptoms are due to paroxysmal disturbance of the electrical activity of the brain. Dorland's Illustrated Medical Dictionary 531 (25th ed. 1974); see also J. Sutherland, H. Taft & M. Eadie, The Epilepsies, Modern Diagnosis and Treatment, 1-2 (2d ed. 1974).

3. R.L. Barrow & H.D. Fabing, Epilepsy and the Law (2d ed. 1966) (hereinafter referred to as Barrow & Fabing). Dean Barrow points out that 15% of all trauma is traceable to the automobile as well as 42% of all accidental deaths. Id. at 5a. See also Finesilver, Legal Aspects of Epilepsy, in Epilepsy Rehabilitation 52 (G. Wright ed. 1976) (hereinafter referred to as Finesilver).
It is appropriate therefore, that in the case of such persons, permission to drive a motor vehicle must be strictly governed by state law. Until about 15 years ago the common approach of state licensing administrators was to deny the driving privilege categorically to epileptic persons and others suffering from impairments affecting their ability to maintain consciousness. In recent years, however, numerous states have adopted less restrictive approaches to the licensing of epileptic drivers. The easing of these restrictions is


Similarly, the converse of this argument is also true. For example, when one drives an automobile, a duty of reasonable care to prevent an accident arises. But, if the driver unforeseeably loses consciousness, the duty of reasonable care is not breached for he cannot reasonably be expected to prevent that which he cannot anticipate or control. Such a defense, however, is not available to epileptic persons who are aware of their seizure predisposition. Because of past seizures, future seizures are arguably foreseeable. Accordingly, numerous courts have ruled that for an epileptic to drive is negligence as a matter of law. Malcolm v. Patrick, 147 So.2d 188 (Fla. 1962); Eleason v. Western Casualty and Surety Co., 254 Wis. 134, 35 N.W.2d 301 (1948); Golembe v. Blumberg, 262 App. Div. 759, 27 N.Y.2d 126 (1941); see also People v. Eckert, 2 N.Y.2d 126, 138 N.E.2d 794 (1956); People v. Decina, 2 N.Y.2d 133, 138 N.E.2d 799 (1956). In these cases, the courts have generally recognized awareness of the disorder's existence as equivalent to actual knowledge a seizure might or would recur. Such awareness fulfilled the foreseeability criterion giving rise to a duty of care toward others. A seizure that recurs while an automobile is being driven clearly heightens the probability that innocent parties may sustain injuries. Thus, the consistent common law ruling held that the duty of care for the epileptic driver required abstention from driving. See Annot. 28 A.L.R.2d 12 (1953). It became necessary, in order to overcome established common law precedent, for numerous individual state legislatures to enact motor vehicle licensing statutes which would permit properly controlled epileptic persons to obtain driver's licenses. See note 5 infra and accompanying text.

attributable, *inter alia*, to the effectiveness of anti-convulsant drugs which has led to the existence of a large group of seizure free epileptic persons who have accrued an admirable record of driving safety when licensed under programs which take their condition into account. In addition, the efforts of the medical profession in educating state legislatures and licensing administrators about the nature and consequences of epilepsy have also played a large role in recent licensure reform.7

The successes registered by the medical profession in this regard have effectively increased the nature and scope of the physician's involvement in the licensure process to the extent that state licensing administrators have become increasingly dependent upon medical judgment and counsel in the exercise of their licensing responsibilities.8 This has placed an enhanced burden upon the physician

6. Finesilver, *supra* note 3, at 52. Modern medical progress in treating epilepsy has resulted in complete control of seizures in fifty percent of all cases. The existence, therefore, of a large group of seizure free epileptics justified a complete re-appraisal of statutes and administrative practices governing issuance of driver's licenses to persons having a history of seizures. It was clear that licensure laws that absolutely prohibited issuance of driver's licenses to epileptic persons drove the epileptic underground and encouraged falsification of applications; this left the epileptic to make the uninformed decision of whether he was a reasonable driving risk.

7. See Barrow & Faring, *supra* note 3, at 62. These efforts include the work of the International Bureau for Epilepsy and the Epilepsy Foundation of America in the creation of the Health, Education and Welfare (HEW) Advisory Commission for the Control of Epilepsy and its Consequences. See U.S. Department of Health, Education and Welfare, Public Health Service, Plan for Nationwide Action on Epilepsy (1977); see also Epilepsy Foundation of America, Basic Statistics on the Epilepsies 147-55 (1975) (hereinafter referred to as Epilepsy Foundation of America). Further efforts are noted on the part of the National Committee on Uniform Traffic Laws and Ordinances in the establishment of their 1972 Uniform Vehicle Code. Id. at 108.

who deals in everyday medical practice with the epileptic patient. The physician is confronted with the ethical and legal dilemma created by opposing duties to patient and public. The physician must balance the intense desire of the patient to obtain valid automobile licensure on one hand against the countervailing public interest in traffic safety on the other.

It is the purpose of this article to offer a resolution to this perplexing dilemma by carefully analyzing and detailing the responsibilities placed upon the Illinois physician by pertinent statutory and common law. In addition, this article will discuss the potential liabilities that a physician practicing in this area may face, as well as the legal protections which the physician can reasonably expect to receive.

**THE PHYSICIAN’S RIGHTS AND RESPONSIBILITIES IN DIAGNOSIS AND TREATMENT**

Fundamentally, the common law places upon the physician the affirmative legal duty to carefully and completely inform the epileptic patient of the nature of the patient’s disease and its attendant risks. Where the epilepsy is poorly controlled, the physician is

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9. One such example of an ethical/legal dilemma requiring a balance of interests between individual and societal concerns is set out in R. Veatch, Case Studies in Medical Ethics (1977). Veatch recites the case of a young man being brought into a private hospital emergency room where the following record was kept on him during a four day period:

- **3/22/71 9:47 A.M.** Admitted to seizure clinic from ER. Reported seizure while walking to work... Patient reports one previous seizure “just like this one” approximately four years ago...
- **Rx diphenylhydantoin 0.1Gm. No.21**
- **3/24/71 EEG confirms suspicion of grand mal.** Patient pleads not to report case to Motor Vehicle Department. Says he only drives 2 times a month—to care for mother who lives alone on the family farm. Says distance is “about 10 miles.” Will consult hospital attorney, but consider primary responsibility is to patient and patient’s mother.
- **3/25/71 Attorney says law in California requires report of all seizure diagnoses.** But does this conflict with medical ethics?

Id. at 120.


11. The question of degree of control is largely a function of the success of therapeutic drug management. Rodin, Medical Considerations, in Epilepsy Rehabilitation 28-50 (G.Wright ed. 1976). The author points out that, for all practical purposes, every epileptic must take medications in order to achieve some measure of control over seizures. The medications that produce specific effects on seizure activity are termed anticonvulsants. Some, such as barbiturates, also have a sedative action. The mechanism by which these drugs operate is still speculative, but it is known that they tend to limit the spread of seizure discharges within the nervous system. In general, the author indicates that the amount of anticonvulsant...
charged with the further responsibility of informing the patient that the epileptic impairment poses a serious driving risk and that the patient must not drive until the prognosis changes.\textsuperscript{12}

The most pertinent and recent judicial decision in this area is \textit{Freese v. Lemmon}.\textsuperscript{13} In \textit{Freese}, a pedestrian brought an action against a motorist and his physician to recover for injuries sustained when the motorist suffered a seizure, lost control of his automobile, and struck a pedestrian.\textsuperscript{14} The motorist had consulted the defendant physician less than three months prior to the accident for diagnosis and treatment regarding a seizure that he had recently suffered.\textsuperscript{15} The complaint alleged that the physician knew of the first seizure suffered by the motorist, but failed to diagnose and ascertain the cause of the seizure or to learn of its recurrence; that the physician negligently failed to employ recognized procedures to determine the cause of the first seizure; that the physician negligently failed to advise the motorist not to drive, failed to warn him of the dangers involved in driving and negligently advised him that he could drive.\textsuperscript{16} The court found that a cause of action against the defendant-physician did exist.\textsuperscript{17} The concurring opinion specifically stated:

If plaintiffs introduce evidence on trial from which a jury could reasonably find, (1) that Dr. Dieckmann negligently advised Lemmon he could drive, (2) that in the exercise of due care Dr. Dieckmann should have expected that members of the public would thereby be put in peril, (3) that Lemmon drove in reasonable reliance upon the advice, (4) that Lemmon suffered a recurrence of his medication the person is required to take tends to be a rough estimate of the severity of the seizure disorder and therefore of the prognosis for complete seizure cessation. A person who needs three or more different anticonvulsants is not likely to become seizure free in the near future. If a patient takes medication in the prescribed dosages but continues to have attacks, it is not feasible to keep on increasing the dosage since side effects will occur; thus, the person will be continuously handicapped. Such an individual is deemed to be a poorly controlled epileptic. \textit{Id.} at 34-37.

12. Freese v. Lemmon, 210 N.W.2d 576 (Iowa 1973); see also Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976), where the court pointed out that, \"[a] doctor must also warn a patient if the patient's condition or medication renders certain conduct, such as driving a car, dangerous to others.\" \textit{Id.} at 436, 131 Cal. Rptr. at 23-24, 551 P.2d at 343. In addition, numerous jurisdictions have held that the special relationship between a doctor and a patient establishes a duty on the part of the physician to exercise reasonable care to protect others against dangers emanating from the patient's illness. See, e.g., Hofmann v. Blackmon, 241 So.2d 752 (App. Fla. 1970); Wojcik v. Aluminum Co. of America, 18 Misc. 2d 740, 183 N.Y.S.2d 351 (1959).


14. \textit{Id.} at 578-79.

15. \textit{Id.}

16. \textit{Id.}

17. \textit{Id.}
malady, (5) that Lemmon struck Lena Freese as a result, and (6) that plaintiffs were thereby damaged, then a jury case would be presented against Dr. Dieckmann . . . .

Freese articulates a distinctive and affirmative duty on the part of the physician to warn a poorly controlled epileptic patient of the hazards of driving, even to the extent of warning strenuously against it. It is essential, therefore, that the substance of all discussions
with a patient relative to these issues be made a part of the patient's medical record. An appropriate medical Record Entry may read as follows:

I have informed the patient that (he) (she) has ____ and that the condition is such as to raise serious doubts of (his) (her) ability to drive for the following reasons. (Set out reasons briefly). The patient understands the hazards posed by (his) (her) condition and has agreed not to drive until the prognosis changes.20

The patient should be invited to initial or sign such an entry whenever possible. In some difficult cases it may be necessary, in order to convince the patient to voluntarily curtail driving, to discuss the situation with a relative who has a strong positive influence on the patient.21 It should be noted, however, that such discussions should take place only after the patient's consent has been obtained.22

THE PHYSICIAN'S REPORTING RESPONSIBILITY

In the event a patient is unwilling to initial an appropriate medical record entry signifying agreement with the physician's diagnosis and recommendations, or where the patient otherwise indicates an unwillingness to heed medical advice regarding the driving impairment, the physician is confronted with the question of whether some further legal obligation or public reporting duty exists. Unlike some states,23 Illinois does not have a mandatory reporting statute.24 The physician must therefore be guided by the exercise of proper clinical judgment. It does not appear that the common law places a duty on the physician to publicly report an epileptic patient's problem where the physician is convinced that the patient understands the nature of the malady and is acting consistent with medical advice to avoid driving.25 The case will differ, however, where the physician

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21. Id. at 25.
22. Id.
23. Barrow & Fabing, supra note 3 at 81, note the existence of such statutes in California, Connecticut, Delaware, Indiana, Montana, Nevada, New Jersey and Oregon.
25. It is interesting to note, however, that the National Committee on Uniform Traffic Laws and Ordinances, in their 1972 Uniform Vehicle Code, recognized that certain mental and physical conditions may create an unreasonable accident risk; the Committee therefore
has a reasonable basis to conclude that the patient is not heeding advice to curtail or avoid driving, or where the physician is in doubt in this regard. In that event, supervening public policy considerations would effectively mandate a breach of physician-patient confidentiality and the filing of an objective, non-conclusory report of the patient's condition to the Illinois Secretary of State or the Illinois Department of Public Health Driver License Medical Advisory Board.

The legal theory underlying such a reporting duty is observed at common law and is set forth in the case of *Tarasoff v. Regents of University of California*. There an action was brought against the University of California and its employed psychotherapists by the parents of Tatiana Tarasoff, a deceased coed. The complaint alleged, *inter alia*, that: two months before the death of their daughter, Tatiana, Prosenjit Poddar, an acquaintance of the young woman, confided to his psychotherapist the intention to kill Tatiana; that his psychotherapists failed to discharge their duty of reporting this confidential disclosure to the deceased woman so as to warn her of the impending danger to her life; and, that their failure to warn her of this threat prevented her from actively taking precautions to protect herself from harm thereby proximately causing her demise. In supporting the cause of action against the defendants, the Supreme Court of California ruled that:

[D]efendant therapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty . . . may call for him to warn the intended victim . . . to notify the police or to take whatever steps are reasonably necessary under the circumstances. The court further stated,

We conclude that the public policy favoring protection of the confidential character of patient-[physician] communications must yield to the extent to which disclosure is essential to avert danger.

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27. *Id.* at 431, 131 Cal. Rptr. at 20, 551 P.2d at 340 (emphasis added).
to others. The protective privilege ends where the public peril begins.28

Thus, to the extent that the Illinois physician reasonably believes the poorly controlled epileptic patient may drive a motor vehicle in contravention of medical advice, a duty exists to notify the proper State licensure authorities of the existing threat so as to mitigate the potential public peril.29 It is important to note that in this regard the physician who voluntarily makes such a report is entitled to substantial common law and statutory protection. Immunity from liability for an alleged breach of confidence is provided by the well entrenched common law doctrine embodied in the following judicial language:

A patient should be entitled to freely disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. . . . This is not to say that the patient enjoys an absolute right, but rather that he possesses a limited right against such disclosure, subject to exceptions prompted by the supervening interest of society.30

28. Id. at 442, 131 Cal. Rptr. at 27, 551 P.2d at 347. The court further noted that, "The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that might be saved." Id. at 440, 131 Cal. Rptr. at 26, 551 P.2d at 346.

29. See Landeros v. Flood, 17 Cal. 3d 425, 131 Cal. Rptr. 69, 551 P.2d 389 (1976). Schwartz v. Thiele, 242 Cal. App. 2d 299, 51 Cal. Rptr. 767 (1966), held that a physician has at least a right, if not a duty, to inform the psychiatric department of the superior court that he believed that the plaintiff was mentally ill. See also Gleeson, Epilepsy: The Doctor and the Law, 10 ACAD. MED. N.J. BULL. 6 (1964), which sets out the facts in the oft quoted New Jersey McCooey case. There McCooey was driving his car on the way to work with five of his fellow employees. Suddenly he became rigid, stiffened out, jammed the gas pedal to the floor and caused a serious accident killing himself and a co-worker and seriously injuring the other passengers. It was determined by one of the plaintiff's investigators that McCooey had been afflicted with convulsive seizures or epilepsy and had been under treatment for the condition over a period of years. Four physicians were found to have been involved in the treatment. These four physicians were then named in the suit. The theory of the action was a failure to report McCooey's condition to the State Board of Health, thereby precluding them from reporting the same to the Motor Vehicle Department which had given McCooey a license. Because McCooey had a license, he was able to drive on the day of the seizure thereby causing the accident. After eight weeks of trial the case was settled by the defendant physicians, lending credence to the legal theory which had been advanced by the plaintiff. For further information in support of a similar public reporting duty, see Hames, Physician Reporting of Driver Impairment, 234 J.A.M.A. 1027 (1975).

30. Hague v. Williams, 37 N.J. 328, 336, 181 A.2d 345, 349 (1962) (emphasis added). In Hague an action was brought against a physician for disclosing to an insurance company medical information about a child for whom the parents had applied to purchase life insurance. In concluding that the disclosure of information was justified, the court ruled:

We conclude, therefore, that ordinarily a physician receives information relating to a patient's health in a confidential capacity and should not disclose such information without the patient's consent, except where the public interest or the private interest of the patient so demands. Without delineating the precise outer contours of the exceptions, it may generally be said that disclosure may, under such compel-
This common law prescription finds support in the *Principles of Medical Ethics* published by the American Medical Association, Section 9, which states:

> A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.\(^{30}\)

In addition to common law protections which are afforded to the physician, significant specific statutory immunity is also provided. The Illinois Driver License Medical Review Act states:

> Information submitted by medical practitioners, police officers, or members of the judiciary. § 13. Any qualified medical practitioner, commissioned police officer, or member of the judiciary may submit information to either the Department or the Secretary of State relative to the physical condition of a person, including suspected chronic alcoholism or habitual use of narcotics or dangerous drugs, if such condition interferes with the person’s ability to operate a motor vehicle safely. Persons reporting under this Section shall enjoy the same immunities granted members of the Board under Section 12.\(^{31}\)

While not specifically iterated, this section of the statute includes epilepsy and other conditions that may result in episodic unconsciousness. The scope of the immunity provided by the referenced Section 12 is hereinafter set forth:

> Liability of persons for information supplied to Board or Department. § 12. No member of the Board, medical practitioner,
clinic, hospital, institution for the mentally ill, both public and private, shall be liable or subject to criminal or civil action for any opinions, findings or recommendations, or for any information supplied to the Board or the Department regarding persons under review by the Department or for any reports required by this Act except for willful and wanton misconduct.  

When the above statutory sections are read together, it is logical to conclude that the qualified medical practitioner who reports information to the Secretary of State or the Department of Public Health Driver License Medical Advisory Board relative to the physical condition of a patient, where such condition interferes with the ability of the patient to operate a motor vehicle safely, will be immune from civil or criminal liability except for actions or disclosures which constitute willful or wanton misconduct. Thus, even a negligent disclosure would be protected. Accordingly, the physician who unknowingly, but nevertheless incorrectly, diagnoses a patient’s condition as poorly controlled epilepsy and subsequently, although negligently, reports the condition to the Secretary of State or Department of Public Health, will likely enjoy statutory immunity from civil or criminal liability for such reporting action. On the other hand, the physician who knowingly or intentionally misrepresents a patient’s condition to the Secretary of State, or fails by virtue of grossly improper and inadequate practice to properly diagnose the patient’s condition thus resulting in the filing of an incorrect report to the Secretary of State or Department of Public Health would be guilty of willful and wanton misconduct and would not be entitled to immunity from liability.

In addition to the common law and statutory protections which are afforded to the physician who reports driver impairment to state authorities, there is a strict confidentiality which attaches to the medical report once it is made:

506.10. Confidential Information. § 10. All information to the Board, the results of all examinations made by the Board or at its direction, and all medical findings of the Board shall be confidential and for the sole use of the Board and the Director for the purposes set forth in this Act. No confidential information may be

33. The phrase “willful and wanton misconduct” is defined in part, to mean a conscious, intentional and utter disregard for the rights of another; an act done with stubborn purpose. Black’s Law Dictionary 1773 (4th ed. 1968).
34. A willful act differs essentially from a negligent act. The one is positive and the other negative. Simple negligence arises merely from heedlessness or a breach of a standard of care, consisting largely of nonfeasance, therefore being incompatible with willfulness which comprises acts of aggressive wrong. Black’s Law Dictionary 1773 (4th ed. 1968).
open to public inspection or the contents disclosed to anyone, ex-
cept the Secretary of State and then only to the extent necessary
to make required reports, unless so directed by a court and then
only when the individual concerned has put the contents of such
confidential information into issue.\(^{35}\)

The existence of the above described confidentiality provision as
well as the other common law and statutory reporting protections
afforded to the Illinois physician create a protective milieu in which
it is clearly advisable for the physician to voluntarily report a pa-
tient’s epileptic condition to the proper State authorities where the
physician has any reasonable basis to believe that the patient may
be disregarding physician directives regarding use of an automobile.
Given the physician’s best use of clinical medical judgment, it is
important to recognize that an error in favor of reporting the pa-
tient’s medical condition will confer immunity upon the physician,
while an error to the contrary may well result in tort liability.\(^{36}\)

**THE PHYSICIAN’S RIGHTS AND RESPONSIBILITIES IN THE LICENSURE
PROCESS**

Perhaps an issue of greater concern to the Illinois physician is that
of exposure to possible civil liability in cases where a patient with
controlled epilepsy is seeking to obtain a driver’s license on the basis
of a physician’s certification. In Illinois, the Secretary of State may
neither renew nor issue licenses or permits to persons who are, or
have been, afflicted with epilepsy.\(^{37}\) Such licenses may only issue if

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“[the epileptic person furnishes] a written verified statement . . . from a competent medical specialist . . .” that he is able to safely operate a motor vehicle. Thus, for the epileptic person to receive an Illinois motor vehicle license, precertification from a competent and well qualified physician must be obtained. Obviously, the physician who receives a request for certification from an epileptic patient must consider many factors. Generally speaking, however, the primary basis for certification will be a medical evaluation and until that person agrees to authorize a competent medical authority to report any change in his condition which would impair his ability to safely operate a motor vehicle. No person who suffers, or has suffered, periods of temporary loss of consciousness shall operate a motor vehicle upon the highways of this State unless and until there is on file, in the Secretary of State’s Office, a statement from a competent medical authority that, in his opinion, the person can safely operate a motor vehicle. Statements submitted in accordance with this rule are for the confidential use of the Secretary of State to implement the provisions of 6-103.8 and will not be otherwise available except by order of a duly constituted Court. This rule is to be retroactive in effect to July 21, 1973.

OFFICE OF THE SECRETARY OF STATE, RULE 6-103.8, as amended, August 5, 1975.

38. See note 37 supra.

39. See, e.g., STATE OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH DRIVER LICENSE MEDICAL ADVISORY BOARD, MEDICAL CRITERIA AFFECTING DRIVER PERFORMANCE (effective Dec. 3, 1976) (adopted pursuant to the Driver License Medical Review Act). These criteria point out some of the general physical and mental characteristics that are necessary in order to drive a motor vehicle:

First of all, the individual has to have the ability to sit in the automobile, hold his head up so that he can apprehend the world in front of him, and then must have sufficient dexterity to operate the controls of the vehicle. We feel that those medical conditions which interfere with proper emotional state, intellectual capacity, or physical control of the vehicle should be fairly self-evident and, where they exist, every attempt should be made to help the individual overcome or circumvent the handicap so that he is able to operate a motor vehicle under full or limited licensure. The following is a tentative list of factors which we consider important:

**Emotional and Intellectual Capacity**

First of all, the individual should have the ability to sustain consciousness throughout the interval in which he attempts to drive. He should be free of distractions of hallucinations, respiratory distress, pain, or other bodily discomforts. He should be free of impulsive behavior, homicidal tendencies, or suicidal tendencies. He should be oriented with advanced preparation of his destination. He should possess the ability to recognize symbols of language and road signs, and possess the ability not only to see objects in his field of vision, but to recognize their significance and to react to them with sufficient speed to avoid catastrophe. He must possess sufficient memory facility to recall his destination, recall the significance of road signs and hazards, and recall the operational control of his vehicle. He must be able to distinguish left from right and to judge distance and relative speed.

**Motor and Sensory Ability**

The individual must possess the ability to sit stably in an erect posture and hold his head erect. In order to amplify the field of vision, he should be able to turn his head at least 25 degrees in either direction. He must possess the use of all four extremities, and have the strength and dexterity to operate the controls of the automobile in a coordinated manner with sufficient speed to react to emergency situations, or possess and use compensating mechanisms for the same purpose.
which discloses that the patient's seizures have been under control for a reasonable period of time, thus allowing prediction with reasonable medical certainty that the seizures will not recur should appropriate precautions be taken, such as continuance of medication, abstention from alcohol, etc. It is important that the physician's medical evaluation in this regard be made in a manner consistent with the established "standard of care." The standard of care

40. Barrow & Fabing, supra note 3, at 75.

41. Basically, medical negligence occurs where it may be said that there has been a failure on the part of the defendant medical practitioner to have complied with the applicable standards of medical practice. D. Harney, Medical Malpractice 88 (1973). In a negligence action against a physician, difficulty arises in trying to ascertain an objective standard against which to measure the defendant's conduct. Id. at 89. It cannot be measured by the physician's own knowledge. Eckleberry v. Kaiser Foundation Northern Hospitals, 226 Or. 616, 359 P.2d 1090 (1961). "A [physician] is presumed to have the necessary medical knowledge to practice his profession. The law cannot equate the mental ability of various individuals; it seeks only to fix a standard by which a jury may determine if the practitioner has properly performed his duties toward his patient." Id. at 625, 359 P.2d at 1094. Nor, as in the usual negligence action, can a court look to the standard of the "reasonable and prudent man under the same or similar circumstances." W. Prosser, Handbook of the Law of Torts § 59 (4th ed. 1971). In an action for medical negligence, the defendant's acts must be measured by the conduct of other physicians. D. Harney, supra at 89; J. Waltz & F. Inbau, Medical Jurisprudence 44-48 (1971); Holder, Medical Malpractice Law 43 (2d ed. 1978).

As early as 1898 the highest court in New York established the basic definition of medical negligence in Pike v. Honsinger, 155 N.Y. 201, 49 N.E. 760 (1898). The plaintiff patient had been kicked in the knee by a horse and claimed that the defendant had set his broken bones in a negligent manner, resulting in a failure of the bones to unite. The court said:

The law relating to malpractice is simple and well settled, although not always easy of application. A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality in which he practices, and which is ordinarily regarded by those conversant with the employment as necessary to qualify him to engage in the business of practicing medicine and surgery. Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgment in exercising his skill and applying his knowledge. The law holds him liable for an injury to his patient resulting from want of the requisite knowledge and skill or the omission to exercise reasonable care or the failure to use his best judgment. The rule in relation to learning and skill does not require the surgeon to possess that extraordinary learning and skill which belong only to a few men of rare endowments, but such as is possessed by the average member of the medical profession in good standing .... The rule of reasonable care and diligence does not require the exercise of the highest possible degree of care, and, to render a physician and surgeon liable, it is not enough that there has been a less degree of care than some other medical man might have shown, or less than even he himself might have bestowed, but there must be a want of ordinary and reasonable care, leading to a bad result.

Id. at 209-10, 49 N.E.762. The Supreme Court of Indiana expanded on this definition in 1938 in the case of Adkins v. Ropp, 105 Ind. App. 331, 14 N.E.2d 727 (1938). There a patient had lost the sight in one eye. He claimed that the defendant had been negligent in removing a foreign body from it thus causing infection. The defendant argued that the infection was an
promulgated in Illinois requires the certifying physician to possess a certain degree of knowledge and skill, and to apply this knowledge and skill with the care that is ordinarily used by reasonably well qualified physicians in similar cases.  

Physicians trained in the diagnosis and treatment of epilepsy who are working with cooperative patients can usually identify those epileptic persons whose seizures are under effective control. Epileptics have a basic seizure pattern in terms of type, frequency and severity of attack. As effective treatment is administered, the sei-

unavoidable result of the original injury. The court said:

'When a physician and surgeon assumes to treat and care for a patient, in the absence of a special agreement, he is held in law to have impliedly contracted that he possesses the reasonable and ordinary qualifications of his profession, and that he will exercise at least reasonable skill, diligence, and care in his treatment of him. This implied contract on the part of the physician does not include a promise to effect a cure, and negligence cannot be imputed because a cure is not effected, but he does impliedly promise that he will use due diligence and ordinary skill in his treatment of that patient so that a cure may follow such care and skill, and this degree of care and skill is required of him, not only in performing an operation or administering first treatments, but he is held to the like degree of care and skill in the necessary subsequent treatment, unless he is excused from further service by the patient himself, or the physician or surgeon upon due notice refuses to further treat the case.'

'In determining whether the physician or surgeon has exercised the degree of skill and care which the law requires, regard must be had to the advanced state of the profession at the time of treatment and in the locality in which the physician or surgeon practices.'

Id. at 334, 14 N.E.2d 728, quoting Adolay v. Miller, 60 Ind. App. 666, 659-60, 111 N.E. 313 (1916).

In Illinois the general rule in a malpractice case is that the plaintiff has the burden to prove the proper standard of care imposed upon the defendant and then to prove by affirmative evidence an unskilled or negligent failure to comply with the standard and a resulting injury. Kwak v. St. Anthony DePadua Hospital, 54 Ill. App. 3d 719, 726, 369 N.E.2d 1346, 1351 (1977); Burrow v. Widder, 52 Ill. App. 3d 1017, 1023, 368 N.E.2d 443, 447 (1977); Simpson v. Johnson, 45 Ill. App. 3d 789, 792, 360 N.E.2d 443, 447 (1977). Unless the matter is within the ken of the layman, to establish a prima facie case, expert medical testimony is necessary to show a lack of care which caused the injury. Id. The standard of care owed by a physician is that degree of knowledge, skill and care which a good physician in the same or similar community would bring to a similar case under like circumstances. Borowski v. Von Solbrig, 14 Ill. App. 3d 672, 680, 303 N.E.2d 146, 150-51, aff'd, 60 Ill. 2d 418, 328 N.E.2d 301 (1975).


43. EPILEPSY FOUNDATION OF AMERICA, supra note 7, at 41; Rodin, Medical and Social Prognosis in Epilepsy, 13 EPILEPSIA 121-31 (1972).

44. Epilepsies are neurological disorders caused by uncontrolled electrical discharges in the brain. Sutherland, supra note 2, at 1-2. Whenever these discharges occur, a person has a seizure. R. SCHMIDT & B. WILDER, EPILEPSY 3 (1968) (hereinafter referred to as SCHMIDT & WILDER). When they strike, the patient becomes unconscious, unaware of physical actions
ure pattern ameliorates. From careful study and observation of the individual patient over a reasonable period of time, the physician is able to determine the effectiveness of the therapeutic program, the accuracy of the patient’s reports and the patient’s reliability.\textsuperscript{45} On the basis of this total clinical impression, the physician will be reasonably capable of making a certification as to the likelihood of a patient’s chances of suffering a recurrence of seizures if the patient

and loses control of bodily movements. W. Lennox, *Epilepsy and Related Disorders* 44 (1960). Additionally, in certain instances the individual may be subject to convulsions. Schmidt \& Wilder, supra, at 11. Although some seizures are quite dramatic and severe, others are slight and go unnoticed. It is in this regard that the various types of epilepsy are classified, i.e., by the various forms of seizure brought about by the different electrical discharges. The most visible and well known epileptic seizure is the *gran mal*, which occurs in most cases of epilepsy. \textsuperscript{Id.} The typical seizure is commenced by an aura, lasting several seconds, followed by extreme convulsion; the sequence of motor events usually proceeds from tonic muscular stiffening to clonic jerks, the body stiffens and, if erect, falls; the arms and legs may be flexed or extended; the bladder frequently empties. The spasms last between two and five minutes and ultimately subside into post convulsive coma. The epileptic may then sleep for a brief period. Upon awakening, the epileptic will experience confusion and loss of memory. \textsuperscript{Id.} Other types of epileptic seizures are less severe, including *petit mal* seizures, myoclonic and akinetic seizures, Jacksonian seizures and psychomotor seizures. Sutherland, supra note 2, at 12, 20. The *petit mal* seizures are usually restricted to childhood, but occur much more frequently than *gran mal* attacks. Although the details of *petit mal* seizures vary widely among individual epileptics, they are all characterized by abrupt onset and termination, brief duration (5-30 seconds) and loss of consciousness. Perr, *Epilepsy and the Law*, 7 Clev-Mar. L. Rev. 280, 284 (1958). After the attack subsides, consciousness returns and the individual usually resumes what he or she was doing. There is no period of confusion and most persons realize that a seizure has occurred. Brava and Bolin, *Epilepsy: A Controllable Disease*, 16 American J. Nursing 388, 390 (1976). Myoclonic and akinetic seizures are “lightning seizures,” which affect either consciousness or muscle control and movement; they occur from five to three hundred times a day and are seldom controlled by medication. These seizures are sudden, last a short time and can be accompanied by a sudden loss of consciousness or muscle jerking. In addition, the epileptic’s face may turn red, white or blue for the duration of the seizure, followed by loss of energy and interest in the surroundings. Sutherland, supra note 2, at 20. The Jacksonian focal motor seizure consists of motor movements which occur in an orderly sequence. The movements involved are usually clonic in nature with the hands most commonly affected; twitching will be observed in the hand and may spread to the arm, face, leg and foot. Schmidt \& Wilder, supra, at 22. The Psychomotor seizure is characterized by inappropriate movements or bizarre behavior without the person realizing that it is occurring. Examples include smacking the lips, sudden changes in emotion, sudden walking in circles, taking off clothes, rubbing arms and legs, hallucinating and other altered states of consciousness. Elapsed time is usually ten to fifteen minutes. U. Jovanovic, *Psychomotor Epilepsy*, A Polidimensional Study (1974). Any one of the above described seizures can occur in conjunction with another. Moreover, that a patient has exhibited only one type of seizure does not preclude the occurrence of some other. The seizures are manifestations of an underlying condition, the consequence of any number of causes including genetic defects, biochemical disorders, infectious disorders, traumatic head injury, birth abnormalities or use of drugs and alcohol. W. Lennox, supra, at 52; Schmidt \& Wilder, supra, at 44-67. In addition, any one of these causes may give rise to one or more seizure types. Despite these considerations, proper treatment with anticonvulsive drugs has resulted in seizure control in eighty percent of the known epileptic population, thereby dramatically and positively changing the lives of epileptic men and women. Barrow \& Fabing, supra note 3, at 25; Schmidt \& Wilder, supra at 142.

\textsuperscript{45} Barrow \& Fabing, supra note 3, at 62.
continues to undergo treatment. In *Compendium of the Epilepsies*, Ernst Niedermayer, M.D. states:

In such requests for medical approval of a driver’s license, EEG improvement over previous tracings is valuable objective evidence; complete EEG normalization is even more desirable but this goal may not be reached in spite of credible seizure freedom. The physician must take very seriously his decision to support (or not to support) the patient’s application; he must find a firm position in the dilemma between his duties to the individual and society.

A favorable physician evaluation will not always be a guarantee that the state will extend the driving privilege to the epileptic person. A more objective evaluation technique is sometimes used. Generally, this objective evaluation is accomplished by determining if the patient has experienced significant seizure control for specific periods of time. While the American Medical Association has recommended a two year seizure free period as a precondition to licensure, several states have adopted shorter seizure free periods of six

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46. *Id.* at 62, 63. For further discussion, see A. Rodin, *The Prognosis of Patients with Epilepsy* 261 (1968) which states:

The occasion may arise that a patient claims he has not had seizures for the past year in order to obtain, for instance, a driver’s license; but the physician has no way of knowing whether the patient’s report is accurate or not. One could now compute the discriminant function using the Lafayette Clinic in-patient formula and predict the probability of the accuracy of the patient’s statement. If the probability were to be .75 or higher for the patient to have seizures, even in the hospital, it might be advisable to admit this particular patient for observation to the hospital rather than simply accept his word as fact.

47. E. Niedermayer, *Compendium of the Epilepsies* 260 (1974) (hereinafter referred to as *Niedermayer*).

48. Niedermayer points out the significance of this consideration when he states that, “it reflects human nature when young adults with a history of unsatisfactory seizure control, suddenly report a miraculous seizure freedom. In a mood of radiant optimism they ask a doctor for a supporting letter to the department of motor vehicles in order to obtain the long desired drivers license.” *Id.* at 259-60.

49. *Committee on Medical Aspects of Automobile Injuries and Deaths, American Medical Association, Medical Guide for Physicians in Determining Fitness to Drive a Motor Vehicle* 22-23 gives physicians the following guide for determining the fitness of an epileptic to drive an automobile:

Epilepsy: Epileptic patients not receiving medicaments and who have been seizure free for a minimum of two years are considered good risks for the operation of private vehicles but should be advised not to drive a commercial or passenger transport vehicle. Such patients should be advised not to consume alcoholic beverages in any form for at least 24 hours prior to driving. Moreover, fatigue should be avoided and six hours should be the maximum number of hours behind the wheel in one day. Also, epileptic patients should be advised that night driving may be particularly dangerous because the photic stimuli from opposing headlights may precipitate a seizure. Emotional stress should be minimized by avoiding driving in peak traffic hours. These patients should be advised to secure a review of their progress and physical condition at least twice a year by a physician. Epileptic
months and one year.\textsuperscript{50} It is noted that states with a one year seizure free period have had favorable accident records for licensed epileptics.\textsuperscript{51} For this reason, certain commentators have recommended that a one year seizure free period be established as the standard for issuance of motor vehicle licenses to controlled epileptics in all states.\textsuperscript{52}

In Illinois, however, despite prior existence of a one year seizure free period guideline,\textsuperscript{53} there currently exists no statutory requirement. Illinois physicians, rather, must certify that the operation of a motor vehicle by an individual patient will not be “inimical to the public safety.”\textsuperscript{54} It may be argued that the Illinois physician is therefore confronted with a more difficult task in determining whether to certify an epileptic person as being medically fit to operate a motor vehicle; however, there are mitigating factors. The common usage of a seizure free period of between six months and two years in certain states,\textsuperscript{55} the existence of medical guidelines established by the American Medical Association’s Committee on Medical Aspects of Automobile Injuries and Deaths and the description of diagnostic standards\textsuperscript{56} in this area, which are set forth in recognized medical texts\textsuperscript{57} and journals,\textsuperscript{58} may all be relied upon in con-

\begin{footnotes}
\item[50.] \textit{Id.} Colorado (one year); Wisconsin and Ohio (six months). \textit{See Epilepsy Foundation of America, supra note 7, at 108; Barrow & Fabing, supra note 3, at 73.}
\item[51.] \textit{Barrow & Fabing, supra note 3, at 74.}
\item[52.] \textit{Id.}
\item[53.] \textit{Id. at 73.}
\item[54.] \textit{Ill. Rev. Stat. ch. 95 \(1/2\) § 6-103(8) (1977).}
\item[55.] \textit{See notes 49-52 supra and accompanying text.}
\item[56.] \textit{Briefly set forth, differential diagnosis of epilepsy begins with history taking, including past medical history (PMH) and family history (FH). W. Lennox, supra note 44, at 362-65. The PMH may reveal a history of birth trauma or other head injuries, such as those sustained in a traffic accident. The FH may show that parents or close relatives have had epileptic or epilepsy-like seizures, since roughly one epileptic in ten has a family history of epilepsy. Id. This inquiry is followed by a complete physical examination and, as necessary or appropriate, a neurological examination with electroencephalograph (EEG) studies, which often provide clear evidence to clinch a diagnosis of epilepsy and identify the type of seizure. E. Niedermayer, supra note 47, at 259-60.}
\item[57.] \textit{See, e.g., F. Forster, Reflex Epilepsy, Behavioral Therapy and Conditional Reflexes (1977); W. Birkmayer, Epileptic Seizures - Behavior - Pain (1976); P. Kellaway & I. Peterson, Quantitative Analytic Studies in Epilepsy (1976); P. Harris & C. Mawdsley, Epilepsy (1974); Aird & Woodbury, The Management of Epilepsy (1974); U. Jovanovic, Psychomotor Epilepsy (1974); E. Niedermayer, supra note 47; Sutherland, supra note 2; L. Boshes & Gibbs, Epilepsy Handbook (2d ed. 1972); H. Gastaut & R. Broughton, Epileptic Seizures (1972); Barrow & Fabing, supra note 3; W. Lennox, supra note 44.}
\end{footnotes}
juncture with the physician’s innate sensitivities and the exercise of sound clinical judgment to aid the physician in reaching an acceptable and legally defensible\textsuperscript{59} decision regarding the certification of an epileptic patient. Thus, where a physician determines that a patient’s motor vehicle licensure would not be “inimical to public safety,” and the determination has been derived at reasonably and in a manner consistent with the prevailing standard of care, the physician will not incur legal liability in the event a patient has an unexpected seizure occurrence which results in a motor vehicle accident causing injury to a third party.\textsuperscript{60}

Concern develops, however, in situations where the physician’s certification of medical fitness to operate a motor vehicle is or may be negligent. In these instances there are a number of substantive and procedural defenses which may be advanced to mitigate or possibly eliminate civil liability.\textsuperscript{61} Perhaps the most effective defense available to the physician is provided by Section 13 of the Driver License Medical Review Act.\textsuperscript{62}

\begin{footnotes}
\item 58. \textsc{E.g.,} \textit{Epilepsia; Journal of Neurology, Neurosurgery and Psychiatry; Neurology; Archives of Neurology.}
\item 59. Reliance on established diagnostic standards, along with the exercise of sound clinical medical judgment, permits the procurement of medical expert witnesses who may testify to the defendant physician’s adherence to the recognized standard of care. See notes 41 and 42 supra and accompanying text.
\item 60. A physician’s conformity with the standard of care, as previously noted, precludes judgment for liability in tort. See notes 41 and 42 supra and accompanying text. In Borowski v. Von Solbrig, 14 Ill. App. 3d 672, 680, 303 N.E.2d 146, 150-51 (1973), aff’d 60 Ill. 2d 418, 328 N.E.2d 301 (1975), the relevant rules of law, in regard to medical malpractice in Illinois, are comprehensively set forth. The court indicates that when a doctor fails to possess and apply the knowledge, skill and care that is ordinarily used by reasonably well qualified doctors in similar cases and circumstances, the physician breaches a duty to the patient. The plaintiff must, however, show by affirmative evidence that the doctor was unskilled or negligent. Proof that a good result is not achieved is not proof of negligence. The plaintiff must show what the average reasonable physician in good standing would have done in a similar case and that the defendant doctor failed to conform his conduct to that norm. Proof of a bad result or a mishap is no evidence of lack of skill or negligence. \textit{Id.} Additional protection from immunity is conferred upon the non-negligent certifying physician by virtue of the statutory language contained in ILL. REV. STAT., ch. 95 1/2 §§ 6-103, 506-12 and 506-13 (1977), referenced in notes 32, 35 and 37, supra.
\item 61. Included among these defenses are: (1) a statutory immunity for other than willful and wanton misconduct set forth in ILL. REV. STAT. (1977) ch. 95 1/2 §§ 506-12 and 506-13. See notes 32, 35 and 37, supra and accompanying text; (2) assertion of established confidentiality provisions regarding the physician’s certifying statement so as to preclude admissibility into evidence or discovery of the same. See ILL. REV. STAT. ch 95 1/2 § 506-10 (1977) and supporting rule issued by the Illinois Secretary of State, notes 35 and 38 supra; and (3) assertion of primary liability on the part of the Secretary of State, the licensing authority, placing jurisdiction in the Illinois Court of Claims. ILL. REV. STAT. ch. 37 § 439.8(d) (1977). See notes 77-83 infra and accompanying text.
\item 62. ILL. REV. STAT. ch. 95 1/2 § 506.1 et seq. (1977). See notes 26-35 supra and accompanying text.
\end{footnotes}
This Section of the Act provides, inter alia, that any physician may submit information to the Department of Public Health or the Secretary of State relative to the physical condition of a person if such condition interferes with the person’s ability to operate a motor vehicle safely. The physical report form in which the Illinois physician is called upon to certify whether a patient is medically fit to operate a motor vehicle safely requires, among other things, that the physician also specifically indicate whether the patient has ever had epilepsy or other seizure disorders: whether the condition is uncontrollable; whether attacks of unconsciousness have occurred within the past six months; whether medication is prescribed for use orally or by injection; and whether the individual takes the medication faithfully. The physician must also set out complete details in answering these questions. All responses should relate objective rather than subjective data. The physical report form must then be sent to the Office of the Secretary of State. The information contained in this report, as well as the physician’s certification of medical fitness, which appears on the face of the aforesaid report, represents a conveyance to the Secretary of State of information relative to the physical condition of a person which potentially interferes with the person’s ability to operate a motor vehicle safely. In this regard, Section 13 of the Driver License Medical Review Act provides that persons reporting such information shall enjoy the immunities granted under Section 12 of the Act. Section 12 provides that no person making reports to the Driver License Medical Advisory Board shall be civilly liable for any opinions, findings or recommendations given except for those which constitute willful and wanton misconduct.

It is evident that the public policy of the State of Illinois, as exemplified in the text of the above referenced statutory sections, encourages physician participation in the motor vehicle licensure process by encouraging physician reporting and certification in ap-

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63. Id.
64. ILL. REV. STAT. ch 95 ½ § 506-13 (1977).
65. It seems reasonable to conclude that this particular question implies the existence or desirability of a requisite six month seizure free period, despite the lack of statutory clarity on this issue.
66. These questions are not mandated by statute but appear on the Medical Report form currently in use by the State of Illinois Office of the Secretary of State, Form No. DSD DC-13.1.
67. This is required by the Office of the Secretary of State. See note 66 supra.
68. Id.
69. See ILL. REV. STAT. ch. 95 ½ § 506-13 (1977).
70. Id.
71. ILL. REV. STAT. ch. 95 ½ § 506-13 (1977).
72. See note 32 supra and accompanying text.
propriate cases even to the extent that the information, opinions, findings or recommendations so conveyed may be negligent.73

Moreover, by rule of the Office of Secretary of State describing which persons shall not be licensed or granted permits,74 it is established that the above referenced physical report forms which are submitted to the Secretary of State are “for confidential use of the Secretary of State to implement the provisions of [Section] 6-103.8 and will not be otherwise available except by order of a duly constituted Court.”75 This language further supports the public policy of the State to encourage physician participation in the motor vehicle licensure process by insuring to the physician maximum confidentiality under the law. The scope of this confidentiality provision provides significant additional procedural protection to the physician who faces a civil action based upon an allegedly negligent certification of an epileptic driver.76

A further protective consideration in this context derives from the fact that the Illinois statute governing motor vehicle licensure vests in the Secretary of State the sole authority to issue licenses.77 The recommendation or certification of a physician regarding the fitness of a particular driver is only one factor involved in the licensure of an individual.78 It is not the physician who licenses the driver; it is the Secretary of State. In this regard, it may be argued that a civil action for injury caused by an improperly licensed epileptic driver should appropriately lie against the Secretary of State rather than the physician who was encouraged by Illinois public policy to participate in the driver license process and who, by rule, confidentially certified to the Secretary of State the driver’s medical fitness.79 This argument is reinforced by the fact that Illinois statute further places upon the Secretary of State an absolute mandate to refer licensure cases to the Driver License Medical Advisory Board where there exists good cause to believe that an individual may not be able to operate a motor vehicle safely.80 Thus, in cases where the Secretary

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73. Only willful and wanton misconduct is delineated as not falling within the purview of the statutory immunity. See ILL. REV. STAT ch. 95 ½ § 506-12 (1977).
74. See note 46 supra.
75. Id.
76. See notes 60 and 61 supra and accompanying text.
77. See, e.g., ILL. REV. STAT ch. 95 ½ § 6-103 (1977).
78. “In this connection, it should be noted that the physician only advises regarding the patient’s medical fitness to drive and the administrator of the drivers license law has the responsibility and control of decision as to issuance or denial of the license.” BARROW & FABING, supra note 2, at 63.
79. Id. See also O’Barr v. Feist, 296 So. 2d 152 (Ala. 1974).
80. ILL. REV. STAT. ch. 95 ½ § 506-5 (1977) reads, “[t]he Secretary of State shall, when he has good cause to believe an individual by reason of his physical disability or use of alcohol
of State, by virtue of significant experience in this area, believes or should believe that an executed physical report form is questionable or perhaps even negligently completed and certified, the Secretary of State has the duty to refer the case to the Driver License Medical Advisory Board for further medical evaluation. 80 The Secretary of State's failure to execute this constructive responsibility breaches a clearly defined statutory duty and may thus serve as the basis for a civil action against the Secretary where an improperly licensed epileptic driver causes injury to a third party. 82

The above discussion demonstrates that a number of legal defenses and statutory immunities may be advanced by a physician facing a civil action based on the theory that the physician incorrectly or negligently certified the medical fitness of an epileptic patient, thereby assisting an incompetent individual to obtain a driver's license and subsequently cause injury to a third party. Ideally, any physician confronted with such a lawsuit will readily be able to establish that the certification in question did not fall below the recognized standard of care and that there is a clear absence of negligence. Unfortunately, the physician who must deal on a day-to-day basis with debatable medical facts and circumstances in certifying the epileptic patient cannot always have such flawless foresight. Fearful of potential legal action, the qualified medical practitioner may become reluctant to participate in the certification process. It is apparent, therefore, that the State, by providing protective immunities and defenses to cooperative physicians, has endeavored to minimize this reluctance and encourage broad scale physician involvement in the driver licensure process. It seems appropriate to conclude, therefore, in light of relevant public policy considerations, available substantive and procedural defenses, and existing statutory immunities, that the physician who certifies the medical fitness of an epileptic patient to drive will largely be protected from civil liability for such action in the absence of willful and wanton misconduct. It is important to note, however, that the physician's responsibilities in these certification cases are continuing and do not cease upon licensure.

THE PHYSICIAN'S RIGHTS AND RESPONSIBILITIES FOLLOWING VALID LICENSURE

Once a patient has been awarded a driver's license, the treating

80. The Secretary of State has the duty to refer the case to the Driver License Medical Advisory Board for further medical evaluation.

81. See ILL. REV. STAT ch. 37 § 439.8(d) (1977) and notes 53, 54, 70 and 72 supra.
physician incurs a further good faith responsibility to comply with the terms of the Driving Agreement which the patient is required to execute. The text of the Agreement reads as follows:

The records of the Secretary of State, Driver Services Department, indicate you have a condition which might impair the safe operation of a motor vehicle.
The records further indicate by competent medical reports that the condition is presently adequately controlled; however, in consideration for the retention or issuance of a drivers license, I agree to the following:

1. I will remain under the care of my physician and follow exactly such treatment as prescribed;
2. I authorize my physician to report immediately any change in my condition which would impair my ability to safely operate a motor vehicle;
3. Any default in this agreement will be sufficient cause for the Secretary of State to cancel, revoke or suspend my driving privileges.
4. I further agree to notify the Secretary of State immediately if I change physicians. 83

In light of the above Agreement, it is the duty of the certifying physician to remain cognizant of the fact that the patient continues under the physician’s care. In the event of any irregularities in this regard the physician must convey such information to the Secretary of State. 84

To the extent that the patient cooperatively remains under the care of the physician there exists the further responsibility to carefully explain to the patient the necessity of taking appropriate medication at certain intervals, or of adhering to other instructions. 85 The physician must be certain that the patient understands the consequences of departing from an established regimen in addition to other potential problems, such as driving at night, under the influence of alcohol or when tired. 86 The patient’s medical record should contain information which reflects the existence of such understanding. 87

Finally, persons who are licensed by virtue of a supporting physician’s statement will be licensed, as are other Illinois drivers, 88 for

83. This Driving Agreement is currently in use by the State of Illinois Office of the Secretary of State. It is the reverse side of the Medical Report form No. DSD DC-13.1 referenced in note 66 supra.
84. Id.
85. Smolin, supra note 5, at 1022; Barnett, supra note 20, at 26.
86. Id.
87. Id.
88. ILL. REV. STAT ch. 95 ½ § 6-115 (1977).
three year periods. This places a continuing responsibility on the physician to maintain and monitor the patient’s medical condition. Every three years the driver’s file will be reviewed by the Office of the Secretary of State. It is important for the physician to be prepared to reaffirm the patient’s fitness for driving at such times. In this regard, careful maintenance of the patient’s medical records is quite important. This will permit the physician to set out, in reasonably objective detail, the medical data upon which the physician’s judgment of fitness is based. The efforts of the physician in this regard will provide both continuing assistance to the epileptic patient, for whom the ability to drive is essential, and a significantly improved medical-legal posture for the physician in the event of a threatened lawsuit.

CONCLUSION

Today, motor vehicle licensure of the controlled epileptic person has become a national reality in which the input of the medical professional is of critical importance. It is therefore essential that broad scale physician involvement in the licensure process be supported and encouraged so as to insure the integrity of this socially important public endeavor. Unfortunately, there exists a unique set of duties and responsibilities attendant to the physician’s involvement in this process which may expose the physician to civil liability. The negative inertia which stems from this increased possibility of litigation stands in obvious opposition to the positive public objective of encouraging broad scale medical professional involvement in the licensure process. It is therefore incumbent upon individual state legislatures to overcome this negative inertia by enacting appropriate legislation to provide certain minimum protections to the physician who wishes to participate in this relatively new medical-legal arena.

In this regard, it seems clear that the Illinois legislature has endeavored to meet its responsibility in encouraging physician involvement in the motor vehicle licensure process. Despite an occasional lack of clarity, numerous protections and immunities have been spelled out for the physician, both in the context of the Driver License Medical Review Act and the Illinois Vehicle Code, as well

89. See Driving Agreement, supra note 83.
90. Virtually all authors writing on medical-legal topics consistently stress the maintenance of comprehensive and complete medical records as a major defensive consideration in medical negligence litigation. See, e.g., A. Holder, Medical Malpractice Law 298-301 (2d ed. 1978); A. Rosenberg & L. Goldsmith, Malpractice Made Easy 140-45 (1976); F. Havit, L. Hayt & A. Groeschel, Law of Hospital Physician and Patient 1125-50 (1972); J. Waltz & F. Inbau, Medical Jurisprudence 139-40 (1971).
as in state administrative rules and regulations enacted pursuant to these laws. Although existing Illinois statutory language could and probably should be amended to more clearly and specifically delineate the nature and scope of available protections,"it is nevertheless evident that the Illinois physician who works with the epileptic patient and understands the rights and responsibilities which attend such involvement, will be entitled to significant protection when participating in good faith in the motor vehicle licensure process.

91. The current Delaware Statute which requires persons who are subject to loss of consciousness to obtain medical certification that their infirmity is under control as a precondition to licensure specifically includes as part of the language of the statutory directive in this regard that, "No physician who examines a person and provides a certificate in good faith in accordance with this subparagraph shall be subject to any civil or criminal liability on account of having provided the certificate." Del. Code Ann. tit. 21 § 2707(7) (Supp. 1974). Such specific language is advisable for inclusion in Ill. Rev. Stat. ch. 95 1/2 § 6-103 (1977).