

January 1994

The Evolution and Status of the Contributory Negligence Defense to Medical Malpractice Actions in North Carolina - *McGill v. French*

Lucinda L. Fraley

Follow this and additional works at: <http://scholarship.law.campbell.edu/clr>

 Part of the [Torts Commons](#)

Recommended Citation

Lucinda L. Fraley, *The Evolution and Status of the Contributory Negligence Defense to Medical Malpractice Actions in North Carolina - McGill v. French*, 16 CAMPBELL L. REV. 103 (1994).

This Note is brought to you for free and open access by Scholarly Repository @ Campbell University School of Law. It has been accepted for inclusion in Campbell Law Review by an authorized administrator of Scholarly Repository @ Campbell University School of Law.

NOTES

THE EVOLUTION AND STATUS OF THE CONTRIBUTORY NEGLIGENCE DEFENSE TO MEDICAL MALPRACTICE ACTIONS IN NORTH CAROLINA — *McGill v. French*

I. INTRODUCTION

Traditionally, the courts' view of the physician-patient relationship was based on the assumption that the physician had knowledge superior to that of the patient, who was regarded as having very little knowledge and experience with medical issues.¹ This assumption has gradually faded over the years and the physician and patient are now placed on practically equal footing.² The courts now impute increased knowledge and awareness of health care issues to the patient.³

As a result, physicians have attacked medical malpractice claims with increasing vigor. No longer can the patient plead ignorance to justify his own negligence.

It is a well settled rule of law that when a patient has by his own negligence, imprudence, or disregard of the directions of his physician, directly contributed to the aggravation of his disease or disorder, he cannot recover damages for anything which is the result of mere negligence or unsuccessful treatment by the physician.⁴

The determination of whether a patient has been negligent rests upon the circumstances of the individual case.⁵ The jurisdic-

1. Sharon W. Murphey, Comment, *Contributory Negligence in Medical Malpractice: Are the Standards Changing to Reflect Society's Growing Health Care Consumerism?*, 17 U. DAYTON L. REV. 151 (1991).

2. *Id.* at 152.

3. *Id.*

4. CHARLES F. BEACH JR., A TREATISE ON THE LAW OF CONTRIBUTORY NEGLIGENCE OR NEGLIGENCE AS A DEFENSE § 406, at 583 (John J. Crawford ed., 3rd ed. 1899).

5. L.S. Tellier, Annotation, *Contributory Negligence or Assumption of Risk as Defense in Action Against Physician or Surgeon for Malpractice*, 50 A.L.R. 2d

tions that have recognized the defense of contributory negligence in medical malpractice actions have granted a remedy in the form of either barring the patient's recovery,⁶ or reducing the patient's damages.⁷ Despite the widespread use of the contributory negligence defense in other jurisdictions, prior to 1993 North Carolina declined to allow a defendant to succeed on the defense in medical malpractice actions.⁸

As a result of *McGill v. French*,⁹ a patient who fails to follow the advice of the physician may be challenged with the contributory negligence defense in a suit alleging medical malpractice. In *McGill*, the court held a patient may be barred from recovering in a medical malpractice action if the patient fails to follow the physician's instructions or advice by not keeping scheduled appointments.¹⁰ This decision could inhibit future claims of medical malpractice since the patient may be completely barred from recovery though only partially at fault.¹¹ The decision emphasizes the patient's responsibility for his own care and return visits for follow-up care.¹²

This Note will examine the defense of contributory negligence, the prerequisites for asserting the defense, and the underlying policy reasons which may explain the rampant growth of the defense and its alleged recent decline. Next, this Note will evaluate the circumstances which have given rise to contributory negligence as well as those circumstances that do not rise to the level of contributory negligence. Finally, this Note will analyze the North

1043, 1045 (1956); 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 303 (1981).

6. See, e.g., *Wisker v. Hart*, 766 P.2d 168 (Kan. 1988) (if patient is fifty percent or more at fault then recovery is barred).

7. See, e.g., *Roers v. Engebretson*, 479 N.W.2d 422 (Minn. Ct. App. 1992) (patient's damages reduced in proportion to amount of patient's fault).

8. *McGill v. French*, 333 N.C. 209, 424 S.E.2d 108 (1993); see also *Powell v. Shull*, 58 N.C. App. 68, 239 S.E.2d 259 (1982), rev. denied, 306 N.C. 743, 295 S.E.2d 479 (1982) (failure to return to doctor's office did not contribute to the patient's injury); *Ballenger v. Crowell*, 38 N.C. App. 50, 247 S.E.2d 287 (1978) (fact that patient becomes addicted to narcotic drugs, continues in doctor's care and knowingly continues his addiction does not make him contributorily negligent).

9. 333 N.C. 209, 424 S.E.2d 108 (1993).

10. *Id.*

11. See William F. Horsley, *The Argument for Comparative Fault*, 38 N.C. ST. B.Q., 18, 19 (Fall 1991) ("An archaic law, one of doubtful ancestry, continues to place 100% of the loss on victims who are no more than 1% at fault.").

12. *McGill*, 333 N.C. at 220-21, 424 S.E.2d at 115.

Carolina Supreme Court's decision to permit the defense when the patient fails to follow the physician's advice and instructions.

II. THE CASE

Plaintiff, Daniel McGill, filed a medical malpractice action against defendant, Dr. Thomas N. French, and the clinic which employed him.¹³ Mr. McGill was referred to Dr. French in July 1982 by Dr. Donald Woolfolk,¹⁴ who had treated Mr. McGill prior to June 1982 for emphysema and two heart attacks.¹⁵ After tests were completed, Dr. French diagnosed Mr. McGill with a mild prostatic enlargement.¹⁶ However, attempts to get in touch with Mr. McGill to communicate the test results were unsuccessful.¹⁷

Over a year passed before Dr. French saw Mr. McGill again.¹⁸ In August 1983, Mr. McGill sought treatment for urinary retention at the hospital emergency room.¹⁹ Mr. McGill was hospitalized and Dr. French performed a prostatectomy.²⁰ The prostatectomy revealed Mr. McGill had prostatic cancer;²¹ however, Mr. McGill was not informed of the diagnosis before discharge from the hospital because it was not included in his medical chart.²²

The following month, Mr. McGill returned to Dr. French's office and was informed of the prostate cancer diagnosis.²³ Dr. French explained that the cancer was malignant,²⁴ that it was

13. *Id.* at 211, 424 S.E.2d at 109.

14. *Id.* at 212, 424 S.E.2d at 110.

15. *Id.* In June 1982, Dr. Woolfolk referred plaintiff to Dr. Thomas Barnett at the University of North Carolina at Chapel Hill School of Medicine for breathing problems. *Id.* Dr. Barnett recommended plaintiff see a urologist for further consultation after discovering a prostatic enlargement. *Id.* Plaintiff then saw Dr. French in July 1982. *Id.* A prostatic enlargement is an enlargement of the chestnut-shaped body that surrounds the beginning of the urethra in the male and secretes a milky fluid at time of the emission of semen. *STEDMAN'S MEDICAL DICTIONARY* 1150 (24th ed. 1982).

16. *McGill*, 333 N.C. at 212, 424 S.E.2d at 110.

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.* A prostatectomy is a surgical procedure to remove all or a part of the prostate. *STEDMAN'S MEDICAL DICTIONARY*, *supra* note 15, at 1150.

21. *McGill*, 333 N.C. at 212, 424 S.E.2d at 110.

22. *Id.*

23. *Id.*

24. A malignancy occurs in severe form, is resistant to treatment and is frequently fatal. *STEDMAN'S MEDICAL DICTIONARY*, *supra* note 15, at 829.

going to cause problems soon, and that a close watch should be kept for the first sign of back or bone pain or any other difficulty.²⁵ Treatment was not administered at this time, but Dr. French told Mr. McGill to return promptly when asked and upon his first experience of pain or discomfort.²⁶ The next appointment was scheduled for October.²⁷

Mr. McGill returned to Dr. French's office prior to his scheduled appointment but missed his scheduled appointment.²⁸ No complaints of pain were made at this time.²⁹ Dr. French reiterated the September discussion with Mr. McGill.³⁰ In addition, Dr. French told Mr. McGill that it did not matter when treatment began because it would not change his life expectancy or quality of life since he was asymptomatic and in an advanced stage of carcinoma.³¹ Thereafter, Mr. McGill missed a scheduled appointment in January 1984.³² According to Dr. French, a notice was sent to plaintiff after Mr. McGill missed the appointment.³³

Mr. McGill's complaint alleged a variation on these facts. The most significant variation was an allegation that Dr. French never told him of the diagnosis.³⁴ In June 1984, Mr. McGill returned to Dr. Woolfolk's office complaining of stomach pain.³⁵ After hospitalizing Mr. McGill, Dr. Woolfolk rechecked the medical records and found the diagnosis.³⁶ The diagnosis was then communicated to Mr. McGill.³⁷ Dr. Woolfolk called Dr. French in for consultation.³⁸ Treatment was recommended and commenced by Dr.

25. *McGill*, 333 N.C. at 212-13, 424 S.E.2d at 110.

26. *McGill*, 333 N.C. at 213, 424 S.E.2d at 110.

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.* Defendant's nurse testified she had the responsibility of contacting a cancer patient who missed an appointment. *Id.* Her efforts included attempting several calls a day and if unsuccessful, then a postcard was sent to the patient. *Id.*

34. *Id.* at 213, 424 S.E.2d at 111.

35. *Id.* at 213, 424 S.E.2d at 111.

36. *Id.* at 214, 424 S.E.2d at 111.

37. *Id.*

38. *Id.*

French.³⁹ The day after treatment began Mr. McGill was discharged and a follow-up appointment was scheduled for July.⁴⁰ Mr. McGill did not keep this appointment and had no further contact with Dr. French.⁴¹

Dr. Woolfolk referred Mr. McGill to Duke Hospital where Dr. David F. Paulson performed a bilateral orchiectomy⁴² in July 1984 after discovering the cancer had spread to the bones.⁴³ Thereafter, Mr. McGill was in and out of the hospital several times until his death in January 1991.⁴⁴

At trial, judgment was entered on the jury verdict finding negligence on the part of Dr. French and contributory negligence on the part of Mr. McGill, thereby dismissing the cause of action.⁴⁵ The North Carolina Court of Appeals reversed the entry of judgment on the verdict and held the trial court should not have submitted the issue of contributory negligence to the jury for two reasons.⁴⁶ First, the court presumed Dr. French's negligence was based upon the failure to inform Mr. McGill of the diagnosis which was only one of several allegations of negligence.⁴⁷ The court concluded that if Mr. McGill had no knowledge of the diagnosis then he could not possibly have been negligent.⁴⁸ Second, the court found Dr. French failed to prove Mr. McGill's injuries were proxi-

39. *Id.* Plaintiff's wife stated she asked defendant why he did not inform them of the diagnosis and he answered that it did not make any difference when treatment began. *Id.*

40. *Id.*

41. *Id.*

42. A bilateral orchiectomy is a surgical procedure to remove both testes. STEDMAN'S MEDICAL DICTIONARY, *supra* note 15, at 992.

43. *McGill*, 333 N.C. at 214, 424 S.E.2d at 111.

44. *Id.* From December 1984 through January 1985, plaintiff was hospitalized for two malignant tumors on his colon. *Id.* Plaintiff returned to the hospital from January 1985 until March 1985 to be treated for pneumonia. *Id.* Plaintiff underwent radiation treatment from April 1986 until June 1986. *Id.* He was subsequently hospitalized several times for pneumonia from October 1986 through January 1990. *Id.*

45. *Id.* at 209, 424 S.E.2d at 108.

46. *Id.* at 211, 424 S.E.2d at 109.

47. *Id.* at 215, 424 S.E.2d at 111. The theories of negligence advanced were (1) failure to institute therapy in 1982, (2) failure to notify referring physician of suspicions in 1982, (3) failure to tell plaintiff of diagnosis, (4) failure to institute therapy in 1983, (5) failure to notify plaintiff's physicians in 1983, (6) failure to monitor with tests, and (7) failure to inform plaintiff's physician that plaintiff did not come in for follow-up treatment in 1983. *Id.* at 215, 424 S.E.2d at 112.

48. *Id.*

mately caused by his own negligence.⁴⁹ The court found the missing link to be the absence of medical testimony establishing a causal connection between the missed appointments and the injuries.⁵⁰ The court of appeals remanded for a new trial on damages only.⁵¹

On discretionary review, the supreme court stated three conclusions. First, the supreme court concluded that the court of appeals erred in assuming the basis for the trial court's finding of negligence was based upon the defendant's failure to inform the plaintiff of his cancer.⁵² The court explained that a reviewing court was not in the position to determine the basis upon which the jury based its verdict without a clear showing of record.⁵³ Second, the court held that proximate cause does not require the defendant to present medical expert testimony in all cases of contributory negligence.⁵⁴ Finally, the court held that there was sufficient evidence for a jury to find a causal connection between missed appointments and the spread or the increased rate of the spread of cancer.⁵⁵ The court ordered the case remanded to the trial court for reinstatement of the judgment entered on the jury verdict.⁵⁶

III. BACKGROUND

A. *The Development of the Defense and the Theoretical Basis Behind Its Development*

Contributory negligence is defined as "conduct on the part of the plaintiff, which contributes to the harm suffered and which falls below the standard to which he is required to conform for his own protection."⁵⁷ The origin of this affirmative defense dates back to the English decision, *Butterfield v. Forrester*.⁵⁸ *Butterfield* set the stage for a litigation revolution.⁵⁹ Lord Ellenborough's

49. *Id.* at 217, 424 S.E.2d at 113.

50. *Id.*

51. *Id.* at 211, 424 S.E.2d at 109.

52. *Id.* at 216, 424 S.E.2d at 112.

53. *Id.*

54. *Id.* at 218, 424 S.E.2d at 113.

55. *Id.* at 221, 424 S.E.2d at 115.

56. *Id.*

57. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 65, at 451 (5th ed. 1984).

58. 11 East 60, 103 Eng. Rep. 926 (1809).

59. BEACH, *supra* note 4, § 8, at 8.

opinion in the case recognized that a plaintiff must use "common and ordinary caution for his own care," thereby relieving the defendant of responsibility for the damage/injury caused by his lack of care.⁶⁰ The defense has increasingly appeared in negligence actions over the years and has emerged as one of the most common defenses in a negligence action.⁶¹

A leading commentator on the subject of tort law has traced the development of contributory negligence as a defense during the nineteenth century to several factors:⁶² (1)the distrust of plaintiff sympathetic juries and the desire to limit the liability of growing industry;⁶³ (2)the tendency to look for a single proximate cause for each injury;⁶⁴ and (3)the courts' inability to create a formula for apportioning damages for a single injury between the parties.⁶⁵ Therefore, though both parties were at fault, only one bore the loss.⁶⁶

The general rules governing the defense of contributory negligence apply to negligence actions asserted by the patient against his physician.⁶⁷ Generally, when the patient's negligence or the negligence of those acting for him proximately causes or contributes to the injury incurred, the patient's contemplated recovery is either barred⁶⁸ or damages are reduced⁶⁹ by the amount of negligence attributable to the patient.⁷⁰ The circumstances under which the defense either bars or reduces recovery vary since each case is reviewed independently.⁷¹

Various theories have been promulgated to explain the general function of the contributory negligence doctrine.⁷² One theory is that the defense serves a penal function as it denies recovery to

60. BEACH, *supra* note 4, § 9, at 9.

61. KEETON ET AL., *supra* note 57, § 65, at 451.

62. *Id.* at 452.

63. *Id.* (citing Wex S. Malone, *The Formative Era of Contributory Negligence*, 41 Nw. U. L. REV. 151 (1947), and arguing that this was the primary factor).

64. *Id.*

65. *Id.*

66. *Id.*

67. Tellier, *supra* note 5, at 1047. For more history on the development of the defense see Fleming James, Jr., *Contributory Negligence*, 62 YALE L.J. 691 (1953).

68. See, e.g., *Wisker v. Hart*, 766 P.2d 168 (Kan. 1988).

69. See, e.g., *Roers v. Engebretson*, 479 N.W.2d 422 (Minn. Ct. App. 1992).

70. 70 C.J.S. *Physicians and Surgeons* § 80 (1987).

71. Tellier, *supra* note 5, at 1045.

72. KEETON ET AL., *supra* note 57, § 65, at 452.

the plaintiff due to his own lack of due care.⁷³ Another theory is that the plaintiff must come into court with clean hands.⁷⁴ The theory advanced by the majority of courts relates to proximate cause.⁷⁵ Most courts frame their opinion in terms of whose negligence was the proximate cause of the injury.⁷⁶

“Proximate cause’ is that cause of an injury which, in natural and continuous sequence, unbroken by any efficient intervening cause, produced the injury, and without which the injury would not have occurred, or it is that act or omission which immediately causes or fails to prevent the injury.”⁷⁷ Generally, recovery is denied if the patient’s negligence is a concurring cause⁷⁸ that is “simultaneous and cooperating with the fault of the physician.”⁷⁹ Negligence on the part of the plaintiff occurring subsequent to the physician’s negligence will reduce the patient’s damages in proportion to his share of the negligence.⁸⁰ While the patient’s negligence does not have to be the sole cause of the injury or damage suffered, it must be a proximate cause to prevent or reduce recovery.

Contributory negligence developed in reaction to the judicial and societal belief that wrongdoers should not be granted relief.⁸¹ In recent years, the defense has suffered criticism as an antique doctrine which has become unsuitable for a changing society.⁸² As social attitudes change, the law must follow. The primary concern

73. *Id.* (citing *Wakelin v. London & S.W.R. Co.*, 12 A.C. 41, 45 (1886)).

74. *Id.* (citing *Davis v. Guarnieri*, 15 N.E. 350 (Ohio 1887)).

75. *Id.* (citing *Thomas v. Quartermaine*, 18 Q.B.D. 685, 697 (1897); *Gilman v. Central Vermont Railway Co.*, 107 A. 122 (Vt. 1919); *Ware v. Saufley*, 237 S.W. 1060 (Ky. 1922); *Exum v. Atlantic Coast Line Railroad Co.*, 154 N.C. 408, 70 S.E. 845; *Chesapeake & Ohio Railroad Co. v. Wills*, 68 S.E. 395 (Va. 1910)).

76. *Id.*

77. *Tellier*, *supra* note 5, at 1044.

78. *See, e.g.*, *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970); *Halverson v. Zimmerman*, 232 N.W. 754 (N.D. 1930); *Sendejar v. Alice Physicians & Surgeons Hosp., Inc.*, 555 S.W.2d 879 (Tex. Civ. App. 1977); *Lawrence v. Wirth*, 309 S.E.2d 315 (Va. 1983).

79. *Tellier*, *supra* note 5, at 1046.

80. *See* cases cited *supra* note 78.

81. *See* Robert A. Leflar, *The Declining Defense of Contributory Negligence*, 1 ARK. L. REV. 1 (1946).

82. Criticism of the defense can be found in Leflar, *supra* note 81. *See also* Fleming James, Jr., *Contributory Negligence*, 62 YALE L.J. 691 (1953). *But see* Richard T. Boyette, *A Case Against Comparative Negligence*, 38 N.C. ST. B.Q. 22 (Fall 1991) (discussion supporting the continued viability of contributory negligence).

of the courts today appears to be just compensation of injured persons.⁸³ Contributory negligence has lost its original rigor and has undergone surgery by courts attempting to modify the doctrine to ameliorate what appear to be harsh effects in an era concerned with providing a remedy for the victim of negligence. The trend is away from barring recovery to reducing recovery proportionately.⁸⁴

B. *Contributory Negligence in Medical Malpractice*

1. *Circumstances in Which the Defense Has Been Successful*

In general, the circumstances under which the defense of contributory negligence has been successful are limited to three primary fact patterns: (1) failure on the part of the patient to disclose a complete and accurate medical history;⁸⁵ (2) patient's refusal to cooperate with the physician in diagnosis or treatment;⁸⁶ and (3) failure to return for further treatment or failure to follow other instructions.⁸⁷

a. Failure to Disclose Complete and Accurate Medical History. The failure of an individual to provide the physician with a complete and accurate medical history may bar recovery.⁸⁸ There are qualifications and limits which apply to the defense in these circumstances. First, the patient is not required to volunteer infor-

83. See generally Leflar, *supra* note 81 (discussing the change in social viewpoint and the disfavor of the defense by the courts).

84. For a discussion regarding this trend see Leflar, *supra* note 81. See also Wex S. Malone, *Some Ruminations on Contributory Negligence*, 1981 UTAH L. REV. 91 (1981).

85. See *infra* notes 88-94 and accompanying text.

86. See *infra* notes 95-100 and accompanying text.

87. See *infra* notes 101-115 and accompanying text.

88. See *Skar v. City of Lincoln*, 599 F.2d 253 (8th Cir. 1979) (patient found to be negligent after he gave physician materially false and misleading information about himself, his medical history, his family history, and his next of kin); *Fall v. White*, 449 N.E.2d 628 (Ind. Ct. App. 1983) (a patient must use reasonable care in giving an accurate medical history to his physician and failure to do so may constitute contributory negligence); *Jensen v. Archbishop Bergan Mercy Hosp.*, 459 N.W.2d 178 (Neb. 1990) (defense of contributory negligence recognized as appropriate when patient intentionally gives erroneous, incomplete or misleading information); *McKoy v. Furlong*, 590 N.E.2d 39 (Ohio Ct. App. 1990) (failure to provide accurate patient history may preclude a finding of negligence on the part of the physician).

mation which the physician does not solicit from him.⁸⁹ This qualification is based on the theory that the patient is not obligated to diagnose his own condition.⁹⁰ The physician is responsible for making necessary inquiries.⁹¹ In addition, the patient does not have to reiterate the information to each of the attending personnel.⁹² The patient is negligent "if a reasonably prudent person would know that the history was false and misleading."⁹³ However, if the patient knows the physician is not aware of, or has not inquired about, a condition that subjects the patient to a risk of danger, then his failure to provide the physician with such information is "unreasonable under the circumstances."⁹⁴

b. Refusal to Cooperate with Physician in Diagnosis or Treatment. The patient has an obligation to cooperate with the physician in both diagnosis and treatment.⁹⁵ A patient who refuses to allow the physician to treat him is responsible for any injury or damage resulting from such refusal.⁹⁶ In general, a patient is

89. *Mackey v. Greenview Hosp. Inc.*, 587 S.W.2d 249 (Ky. Ct. App. 1979) (although the patient has a duty to provide accurate information, the physician must ask questions sufficient to produce the information).

90. *Id.* See also *Santoni v. Moodie*, 452 A.2d 1223 (Md. Ct. Spec. App. 1982) (patient not in a position to judge whether the prescribed course of treatment is in his best interest and as a consequence cannot be negligent for following the doctor's instructions/advice); *O'Neil v. State*, 323 N.Y.S.2d 56 (N.Y. Ct. Cl. 1971) (patient not required to diagnose himself as a drug addict).

91. *Mackey*, 587 S.W.2d at 255.

92. Patient "was under no duty to reiterate her entire medical history to each of the hospital personnel with whom she came in contact but was entitled to rely upon the skill of her personal physician and the competence of the specialists into whose care and keeping she had been committed for examination." *Favalora v. Aetna Casualty & Sur. Co.*, 144 So. 2d 544, 550 (La. Ct. App. 1962).

93. *Mackey*, 587 S.W.2d at 255.

94. *Id.* at 256.

95. *Skar v. City of Lincoln*, 599 F.2d 253, 260 (8th Cir. 1979) (patient has a duty to cooperate with a treating physician to the extent he is able which includes providing accurate information upon request); *Hunter v. United States*, 236 F. Supp. 411 (M.D. Tenn. 1964) (failure of a patient to follow the advice of the physician or to submit to treatment will negate any liability of the physician which includes the failure to obtain consent to treatment); *Stager v. Schneider*, 494 A.2d 1307 (D.C. 1985) (patient has a duty to cooperate with her doctor in proper diagnosis and treatment which does not include a requirement that the patient inquire about test results); *Corlett v. Caserta*, 562 N.E.2d 257 (Ill. App. Ct. 1990) (failure to submit to reasonable life-saving treatment based upon religious beliefs reduces the patient's recovery).

96. 70 C.J.S. *Physicians and Surgeons* § 80 (1987).

bound to submit to treatment which a physician of ordinary skill would prescribe.⁹⁷

A disproportionate number of cases have involved the patient's refusal of treatment based upon religious beliefs.⁹⁸ In determining whether such refusal should constitute contributory negligence the courts are faced with constitutional implications.⁹⁹ In general, the courts have held that denying recovery or reducing recovery when a patient refuses treatment based upon religious beliefs does not violate the First Amendment.¹⁰⁰

c. Failure to Return for Further Treatment as Instructed or Failure to Follow Other Instructions.

(i) Failure to Return for Further Treatment. Once the patient has consulted the physician for treatment and the physician has begun treatment, the failure of the patient to return for further treatment will generally constitute contributory negligence.¹⁰¹ Some courts have reduced damages rather than barring recovery

97. *Id.*

98. See, e.g., *Munn v. Algee*, 924 F.2d 568 (5th Cir. 1991), *cert. denied*, 112 S. Ct. 277 (1991) (free exercise clause not violated by application of mitigation of damages doctrine where patient would not receive blood based on religious beliefs); *Corlett v. Caserta*, 562 N.E.2d 257 (Ill. App. Ct. 1990) (free exercise clause not violated by allocation of liability to patient who refused blood transfusion based upon religious beliefs). *But see* *Montgomery v. Board of Retirement of Kern County Employees' Retirement Ass'n*, 109 Cal. Rptr. 181 (1973) (violated free exercise clause to deny retirement benefits based on refusal to undergo surgery due to religious beliefs).

99. See *Munn*, 924 F.2d at 574; *Corlett*, 562 N.E.2d at 263.

100. See *Munn*, 924 F.2d at 574; *Corlett*, 562 N.E.2d at 263.

101. *Roers v. Engebretson*, 479 N.W.2d 422 (Minn. Ct. App. 1992) (nine month delay in returning to doctor contributed to increase in size of tumor); *Grippe v. Momtazez*, 705 S.W.2d 551 (Mo. Ct. App. 1986) (failure to return as instructed contributed to the doctor's failure to diagnose cancer at an early stage); *Donathon v. McConnell*, 193 P.2d 819 (Mont. 1948) (patient who failed to return to dentist, after being instructed to do so, was barred from recovery); *Mecham v. McLeay*, 227 N.W.2d 829 (Neb. 1975) (patient was negligent in not making an appointment to see her doctor professionally after he instructed her to do so); *Williams v. Wurdemann*, 128 P. 639 (Wash. 1912) (a patient who employs a physician to treat him, receives proper treatment, fails to return for further treatment and suffers injury as a consequence is barred from recovery); *Sanderson v. Moline*, 499 P.2d 1281 (Wash. Ct. App. 1972) (termination of treatment is a factor to be considered in establishing damages but does not relieve the defendant of liability for damage up to time of discontinuance of treatment). *But see* *Maertins v. Kaiser Found. Hosps.*, 328 P.2d 494 (Cal. Dist. Ct. App. 1958) (refused to apply contributory negligence where there was no evidence the patient's failure to return was a proximate cause of the injury).

when the physician's negligence occurred prior to the patient's failure to return for further treatment.¹⁰² These courts have concluded that even though the physician was negligent, the patient's subsequent withdrawal from treatment increased the injury or damage incurred.¹⁰³

The patient is, however, allowed to recover when the patient quits the physician's treatment due to a belief that the physician has treated him negligently.¹⁰⁴ In addition, employing another physician under these circumstances does not constitute negligence on the part of the patient.¹⁰⁵ In fact, the failure to consult another physician after withdrawing from a negligent physician's treatment may prevent the patient from recovering.¹⁰⁶

Generally, to successfully assert the contributory negligence defense, the physician must instruct the patient to return for treatment.¹⁰⁷ If the physician considers the treatment complete and does not order the patient to return, the patient cannot be negligent in failing to return.¹⁰⁸ In addition, a mere delay in seek-

102. *Quinones v. Public Adm'r*, 373 N.Y.S.2d 224 (N.Y. App. Div. 1975) (patient's failure to follow instructions subsequent to the physician's negligence reduces damages to the degree such failure increased the extent of the injury). *See also Heller v. Medine*, 377 N.Y.S.2d 100 (N.Y. App. Div. 1975); *Bird v. Pritchard*, 291 N.E.2d 769 (Ohio Ct. App. 1973).

103. *See, e.g., Quinones*, 373 N.Y.S.2d at 226; *Heller*, 377 N.Y.S.2d at 102; *Bird*, 291 N.E.2d at 771-72.

104. *Halverson v. Zimmerman*, 232 N.W. 754 (N.D. 1930) (discharge of physician by a patient who believes he has been injured by the negligence of the physician and who subsequently employs another physician does not constitute contributory negligence).

105. *Id.*

106. *Id.* at 759. "The patient is not bound to call in other physicians, unless he becomes fully aware that the physician has not been, and is not, giving proper treatment." *Id.* *See also Rahn v. United States*, 222 F. Supp. 775 (S.D. Ga. 1963).

107. *Lauderdale v. United States*, 666 F. Supp. 1511 (M.D. Ala. 1987) (a sufficient warning of the importance in returning must be given to the patient); *Sorina v. Armstrong*, 554 N.E.2d 943 (Ohio Ct. App. 1988) (patient given sufficient information and instruction to know follow-up care was necessary and failure to return for such care was negligence).

108. *Wells v. Woman's Hosp. Found.*, 286 So. 2d 439 (La. Ct. App. 1973), *writ denied*, 288 So. 2d 646 (La. 1974) (patient who was told to go home and was not told to return for treatment was not negligent in failing to keep later appointment); *Corbett v. Weisband*, 551 A.2d 1059 (Pa. Super. Ct. 1988), *appeal denied*, 569 A.2d 1367 (Pa. 1989), and *appeal denied sub nom. Corbett v. DeMoura*, 571 A.2d 383 (Pa. 1989), and *appeal denied sub nom. Petition of DeMoura*, 571 A.2d 383 (Pa. 1989) (patient discharged from hospital by physician cannot be contributorily negligent).

ing treatment or returning for further treatment will not relieve the physician from his duty to provide the patient with proper treatment under the circumstances.¹⁰⁹

(ii) *Failure to Follow Other Instructions.* The failure to follow other instructions or advice, excluding failure to return for further treatment, may also be a basis for contributory negligence.¹¹⁰ "It is the duty of the patient to follow the reasonable instructions and submit to the reasonable treatment prescribed by his physician or surgeon."¹¹¹ The courts appear to distinguish between two situations in this context: (1) situations in which such a failure is the proximate cause of the injury or damage; and (2) situations in which such a failure occurs subsequent to the physician's negligence.¹¹² To constitute a bar to recovery the patient's negligence "must unite in producing the injury."¹¹³ If the patient's negligence is subsequent to the physician's negligence then the patient's damages are reduced, "preventing recovery to the extent the patient's injury was aggravated or increased by his own negligence."¹¹⁴ The patient may, however, disregard instructions or advice which are improper.¹¹⁵

109. *LaRoche v. United States*, 730 F.2d 538 (8th Cir. 1984) (four month delay in returning for further treatment did not relieve dentist of duty of proper care under the circumstances which included considering whether to recommence the original treatment).

110. *Songer v. Bowman*, 804 P.2d 261 (Colo. Ct. App. 1990) (damages reduced due to patient's failure to follow advice regarding use of medication); *Harris v. Cacdac*, 512 N.E.2d 1138 (Ind. Ct. App. 1987) (although patient's negligence in failing to follow advice to exercise her neck following surgery was subsequent to the physician's negligence, a reduction of damages may be appropriate); *Fall v. White*, 449 N.E.2d 628 (Ind. Ct. App. 1983) (patient negligent due to failure to submit to blood test and return for further evaluation as instructed); *Eoff v. Hal & Charlie Peterson Found.*, 811 S.W.2d 187 (Tex. Ct. App. 1991) (patient negligent due to failure to follow physician's advice to return to emergency room). The following cases recognized the rule but found it inapplicable due to a lack of proximate cause. *Crosby v. Grandview Nursing Home*, 290 A.2d 375 (Me. 1972); *Hackathorn v. Lester E. Cox Medical Ctr.*, 824 S.W.2d 472 (Mo. Ct. App. 1992); *Jensen v. Archbishop Bergan Mercy Hosp.*, 459 N.W.2d 178 (Neb. 1990).

111. *Josselyn v. Dearborn*, 62 A.2d 174, 181 (Me. 1948) (citing *Merrill v. Odiorne*, 94 A. 753 [(Me. 1915)]). See also *Crosby v. Grandview Nursing Home*, 290 A.2d at 382.

112. *Harris v. Cacdac*, 512 N.E.2d at 1139-40.

113. *Id.* at 1140.

114. *Id.* at 1140.

115. See *Dunn v. Catholic Medical Ctr.*, 389 N.Y.S.2d 123 (N.Y. App. Div. 1976) ("While a patient is justified in disregarding instructions which are improper, the

2. *Circumstances in Which the Defense Has Failed*

There are several prevalent circumstances under which the courts have concluded the defense of contributory negligence is not appropriate. First "[t]he physician-patient relationship permits a patient to rely on a doctor's professional skill and advice."¹¹⁶ A patient who acts according to his doctor's instructions and incurs injury or damage as a result is not negligent.¹¹⁷ Second, since a patient is entitled to rely on the physician's professional skill and advice, recovery for the physician's negligence is not barred or reduced by failing to consult a second physician or obtain a second opinion unless the patient has reason to believe he is not being properly treated.¹¹⁸ "It is not contributory negligence to follow the advice of a physician without distrusting the physician and appealing to other physicians to check the opinion."¹¹⁹ The patient is not required to question the physician's instructions or advice prior to following them unless fully aware the treatment is not proper. Third, another category relates to the physician's failure or inability to communicate test results and the patient's subsequent failure to inquire about the test results. Generally, the patient does not have a duty to inquire about test results.¹²⁰ To place such a duty on the patient would "invert the duty by transferring it from the health professional to the patient."¹²¹

patient has the duty to exercise reasonable care."). The fact patterns discussed above are the most common circumstances in which the courts have either barred or reduced the patient's damages based upon contributory negligence, but are by no means the sole fact patterns under which the defense may be successful. *See, e.g.,* Tisdale v. Johnson, 339 S.E.2d 764 (Ga. Ct. App. 1986) (patient took drug for eight years without telling doctor of side effects); Ray v. Wagner, 176 N.W.2d 101 (Minn. 1970) (virtually impossible for a doctor to communicate with a patient who has no phone and provides misleading information); Ostrowski v. Azzara, 545 A.2d 148 (N.J. 1988) (not unfair to expect patient to help avoid consequences of condition treated for, which includes honoring dietary restrictions, testing blood sugar and eliminating smoking).

116. Mikkelsen v. Haslam, 764 P.2d 1384, 1388 (Utah 1988).

117. 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 303 (1981). *See infra* note 118 and accompanying text.

118. 70 C.J.S. *Physicians and Surgeons* § 80 (1987).

119. Mikkelsen v. Haslam, 764 P.2d at 1388. *See also* Lawrence v. Wirth, 309 S.E.2d 315 (Va. 1983); Santoni v. Moodie, 452 A.2d 1223 (Md. Ct. Spec. App. 1982).

120. Stager v. Schneider, 494 A.2d 1307 (D.C. 1985); Ray v. Wagner, 176 N.W.2d 101 (Minn. 1970).

121. Stager v. Schneider, 494 A.2d at 1312.

Finally, the defense of contributory negligence has also been asserted by physicians when patients in their care commit suicide. The courts unanimously hold that where there is a duty to prevent suicide, the suicide which results as a breach of that duty cannot establish a defense to liability for breach of that duty.¹²² Thus, a patient with suicidal tendencies is not held to the same standard of care of other patients, that of a reasonable person under the circumstances.¹²³

IV. ANALYSIS

Although the few decisions in North Carolina addressing contributory negligence in medical malpractice did not expressly articulate it, prior to 1993 the courts appeared to be adamant in protecting the patient and compensating the patient for injury or damage suffered at the hands of the physician. The North Carolina Supreme Court addressed the issue of contributory negligence in medical malpractice actions only twice prior to 1993.¹²⁴ The court held in both cases that no contributory negligence existed. In 1993, with *McGill v. French*,¹²⁵ the supreme court drastically shifted position by denying recovery to a patient based upon his own negligent contribution to his injury for the first time.

122. See *Brandvain v. Ridgeview Inst. Inc.*, 372 S.E.2d 265 (Ga. Ct. App. 1988), *aff'd*, 382 S.E.2d 597 (Ga. 1989); *McNamara v. Honeyman*, 546 N.E.2d 139 (Mass. 1989); *Cowan v. Doering*, 545 A.2d 159 (N.J. 1988); *Hoeffner v. The Citadel*, 429 S.E.2d 190 (S.C. 1993). *But see Bourne v. Seventh Ward Gen. Hosp.*, 546 So. 2d 197 (La. Ct. App. 1989) (medical malpractice action brought against physician for treatment subsequent to attempted suicide not barred by negligence of patient in attempting suicide).

123. *Cowan v. Doering*, 545 A.2d at 162 (a mentally disturbed plaintiff's conduct is measured in light of his mental condition). Once again these are not the only circumstances under which the courts have rejected the defense of contributory negligence, but they are the most litigated. For other cases in which the contributory negligence defense was rejected, see *Fabianke v. Weaver*, 527 So. 2d 1253 (Ala. 1988) (unborn child cannot be guilty of contributory negligence); *Wheatley v. Heideman*, 102 N.W.2d 343 (Iowa 1960) (two year old child cannot be guilty of contributory negligence); *Kelly v. Carroll*, 219 P.2d 79 (Wash. 1950), *cert. denied*, 340 U.S. 892 (1950) (patient does not assume the risk of incompetent treatment by a drugless healer).

124. See *Powell v. Shull*, 58 N.C. App. 68, 293 S.E.2d 259 (1982), *rev. denied*, 306 N.C. 743, 295 S.E.2d 479 (1982); *Ballenger v. Crowell*, 38 N.C. App. 50, 247 S.E.2d 287 (1978).

125. *McGill v. French*, 333 N.C. 209, 424 S.E.2d 108 (1993).

A. Preliminary Issues

1. Basis of the Jury Verdict

In *McGill* the court was faced with two preliminary issues. The first issue addressed by the court was whether the court of appeals erred in presuming defendant's negligence was based upon only one of several allegations of negligence.¹²⁶ The court of appeals presumed the defendant's negligence was based upon the failure to inform plaintiff of the cancer diagnosis.¹²⁷ The court of appeals concluded that since plaintiff had no knowledge of the illness he could not be negligent.¹²⁸ Plaintiff stated seven different allegations of negligence¹²⁹ and offered evidence to support at least four.¹³⁰ The jury could have based its verdict upon any one of the allegations supported by evidence. The court held that a reviewing court cannot determine the basis for a jury's verdict absent clear proof of that basis.¹³¹ This decision is consistent with prior decisions of the court, some of which the court made reference to.¹³²

2. Proximate Cause

The second preliminary issue addressed by the court was whether proximate cause in medical malpractice cases required medical expert testimony.¹³³ The standard to be applied was clearly established in previous cases;¹³⁴ therefore, the court quickly disposed of the issue.

126. *Id.*, at 215, 424 S.E.2d at 111.

127. *Id.*

128. *Id.*

129. See *supra* note 47.

130. *McGill*, 333 N.C. at 215, 424 S.E.2d at 111-12.

131. *Id.* at 216, 424 S.E.2d at 112.

132. The cases cited by the court were factually different from *McGill*, yet they affirmed the principle propounded by the court. See, *Bittle v. Jarrell*, 270 N.C. 266, 154 S.E.2d 43 (1967) (the judge mistakenly used the word "defendant" instead of "plaintiff" in his charge to the jury regarding contributory negligence); *Barber v. Heeden*, 265 N.C. 682, 144 S.E.2d 886 (1965) (conflicting instructions regarding burden of proof were given to the jury); *In re Will of Shute*, 251 N.C. 697, 111 S.E.2d 851 (1960) (conflicting instructions given to the jury and court could not say the jury followed the correct one).

133. *McGill*, 333 N.C. at 218, 424 S.E.2d at 113.

134. See *Chapman v. Pollock*, 69 N.C. App. 588, 594, 317 S.E.2d 726, 731 (1984); *Powell v. Shull*, 58 N.C. App. 68, 71, 293 S.E.2d 259, 261 (1982), *rev. denied*, 306 N.C. 743, 295 S.E.2d 479 (1982); *Jackson v. Mountain Sanitarium & Asheville Agric. Sch.*, 234 N.C. 222, 227 67 S.E.2d 57, 61-62 (1951).

Although under the general rule the plaintiff is required to establish a causal connection between the negligence of the physician and the injury by medical expert testimony,¹³⁵ an exception exists if the jury “based on its common knowledge and experience, is able to understand and judge the action of a physician or surgeon.”¹³⁶ The court applied this same exception to the causal relationship between the patient’s negligence and the injury.¹³⁷ Based upon the standard of care required of a plaintiff, “that of a person of ordinary prudence acting under the same or similar circumstances,” the court reasoned that the jury, “based on its own knowledge and experience,” could determine whether the failure to return for follow-up care or the failure to call contributed to the rate of spread of the disease.¹³⁸ This rule was adopted and applied in previous cases;¹³⁹ however, since contributory negligence has seldom been addressed in medical malpractice cases in North Carolina the analysis performed by the court was necessary.

B. *The Contributory Negligence Issue*

The court’s remaining analysis centered on whether the defendant had met his burden of proof. “A party asserting the defense of contributory negligence has the burden of proof of such defense.”¹⁴⁰ The plaintiff is not required to prove he/she was not negligent. The court defined the issue as being whether the trial court erred in submitting the issue of contributory negligence to the jury where the evidence consisted of the plaintiff’s failure to keep one or more appointments with the defendant physician.¹⁴¹ The court resolved the issue on the basis of applicable precedent and expert testimony given at trial.¹⁴²

1. *Precedent: Powell v. Shull*

a. *Application of the Facts to the Rule in Other Jurisdictions.* The court compared and contrasted the case with a previous deci-

135. N.C. GEN. STAT. § 90-21.12 (1975 & Supp. 1992); *Moore v. Reynolds*, 63 N.C. App. 160, 163, 303 S.E.2d 839, 841 (1983); *Ballenger v. Crowell*, 38 N.C. App. 50, 54, 247 S.E.2d 287, 291 (1978).

136. *Powell*, 58 N.C. App. at 71, 293 S.E.2d at 262. See also *Chapman*, 69 N.C. App. at 594, 317 S.E.2d at 731; *Jackson*, 234 N.C. at 227, 67 S.E.2d at 61-62.

137. *McGill*, 333 N.C. at 219, 424 S.E.2d at 114.

138. *Id.*

139. See *supra* note 134 and accompanying text.

140. N.C. GEN. STAT. § 1-139 (1983 & Supp. 1992).

141. *McGill*, 333 N.C. at 219, 424 S.E.2d at 114.

142. *Id.* at 218-21, 424 S.E.2d at 113-15.

sion, *Powell v. Shull*,¹⁴³ a case in which the defendant also asserted contributory negligence based upon the patient's failure to keep appointments.¹⁴⁴ In *Powell*, the plaintiff alleged Dr. Shull had negligently treated her between April 17, 1977 and August 2, 1977 for a fractured arm.¹⁴⁵ The court found there was a progressive slippage and an increase in displacement of the fracture.¹⁴⁶ The displacement was estimated by a radiologist to be 100% by July 1, 1977.¹⁴⁷ The plaintiff had kept all appointments during that period.¹⁴⁸ The plaintiff's failure to return to Dr. Shull's office did not occur until after August 2, 1977, which was subsequent to Dr. Shull's alleged negligence; therefore, the court held that she could not have been negligent.¹⁴⁹ In addition, the court noted that there was no evidence to indicate that the degree of deformity in her arm would have been decreased by anything she did prior to or after August 2, 1977.¹⁵⁰

The court's conclusion in *Powell* was logical. A patient's negligence which occurs subsequent to the physician's negligence cannot contribute to the injury incurred on that prior date. However, most courts would go one step further and reduce the damages recoverable due to subsequent negligence which aggravated the injury.¹⁵¹ These courts would reduce recovery in proportion to any increase in the injury from the time plaintiff left defendant's care until plaintiff consulted the second physician.¹⁵² The court did not consider such a reduction and focused only on any injury received while in the defendant's care prior to the missed appointments. The court stated there was a lack of evidence to prove anything plaintiff did after leaving the defendant's care aggravated the injury.¹⁵³ Reduction of damages was not considered in *McGill* either. The court did not address the plausibility of allocating neg-

143. *Powell v. Shull*, 58 N.C. App. 68, 293 S.E.2d 259 (1982), *rev. denied*, 306 N.C. 743, 295 S.E.2d 479 (1982).

144. *Id.* at 76, 293 S.E.2d at 263.

145. *Id.* at 76, 293 S.E.2d at 264.

146. *Id.*

147. *Id.*

148. *Id.* at 77, 293 S.E.2d at 264.

149. *Id.*

150. *Id.* The court's conclusions were not supported by any precedent in the opinion.

151. *See supra* text accompanying notes 112-114. *See also* Tellier, *supra* note 5, at 1047 (summarizing the general rule).

152. *See supra* text accompanying note 114.

153. *See supra* text accompanying note 150.

ligence between Mr. McGill and the defendant. Instead, once the court determined there was contributory negligence, recovery was barred.

b. Distinguishing Powell and McGill. In applying *Powell* to the *McGill* facts, the court distinguished the two cases. The "critical difference" the court noted was that Mr. McGill failed to keep appointments "during a crucial time of his illness," whereas the plaintiff's injury in *Powell* reached its worst while she was attending scheduled appointments.¹⁵⁴ In September and October 1983, Dr. French instructed Mr. McGill to return for treatment upon experiencing pain or other symptoms.¹⁵⁵ Mr. McGill experienced weight loss and weakness from the time he was released from the hospital in September 1983 until December 1983, yet Mr. McGill did not contact Dr. French.¹⁵⁶ From December 1983 until June 1984 Mr. McGill was weak and could not do things which he normally could do without having to stop and rest, yet he did not contact Dr. French.¹⁵⁷ Mr. McGill was told of the importance of keeping scheduled appointments and of contacting Dr. French upon the first sign of symptoms but disregarded both instructions.¹⁵⁸ The court concluded that, unlike the plaintiff in *Powell*, if Mr. McGill had appeared at his scheduled appointments and returned to Dr. French's office as he was instructed, then the cancer might not have spread as fast as it did.¹⁵⁹

A distinction between the two cases which may aid in reconciliation of the decisions is the character of the defendant's conduct. The defendant in *Powell* had given no indication he was going to perform further surgery and in fact told the plaintiff the fracture was healing and that she could return to work and chop wood.¹⁶⁰ The defendant in *McGill* specifically instructed the plaintiff on the need to return upon the first sign of pain or other symptoms so that treatment could begin.¹⁶¹ The defendant in *Powell* gave every indication that no further treatment or surgery was to

154. *McGill*, 333 N.C. at 220, 424 S.E.2d at 114.

155. See *supra* text accompanying notes 26-30.

156. *McGill*, 333 N.C. at 220, 424 S.E.2d at 115.

157. *Id.*

158. See *supra* text accompanying note 26.

159. *McGill*, 333 N.C. at 221, 424 S.E.2d at 115.

160. *Powell*, 58 N.C. App. at 72-3, 293 S.E.2d at 262.

161. See *supra* text accompanying note 26.

be performed.¹⁶² Had the plaintiff in *McGill* returned for scheduled appointments as instructed, treatment would have been commenced; whereas, in *Powell* further treatment was not contemplated.

The court found that Mr. McGill's failure to contact Dr. French or any other physician upon experiencing the first symptoms was most damaging to his case.¹⁶³ The fact that Mr. McGill failed to keep scheduled appointments was recognized, yet this fact received less emphasis than the fact that he failed to follow Dr. French's instructions and to return upon the first sign of symptoms.

The allegation of contributory negligence in *Powell* was also based upon the failure to keep scheduled appointments.¹⁶⁴ The court's deemphasis of the failure to keep scheduled appointments in *McGill* and the court's holding of no contributory negligence in *Powell* suggests that the failure to keep scheduled appointments by itself may not be enough when alleging contributory negligence in North Carolina contrary to holdings in other jurisdictions.¹⁶⁵

2. *Expert Medical Testimony*

Powell was the only precedent from which the court drew its opinion; however, the court referred to expert medical testimony given at trial.¹⁶⁶ This testimony addressed three issues. First, the testimony addressed the societal change in attitude toward the physician-patient relationship.¹⁶⁷ The experts emphasized that the responsibility for a patient's well-being is shared by the physician and patient.¹⁶⁸ The patient's responsibility, they postulated, includes keeping scheduled appointments.¹⁶⁹ Second, the expert testimony indicated that even if Mr. McGill was not informed that he had cancer, as he alleged, there would have been symptoms

162. The emphasis on returning generally required in other jurisdictions, see *supra* note 107 and accompanying text, was missing in *Powell*. In fact, in *Powell* there appeared to be a total lack of such emphasis.

163. *McGill*, 333 N.C. at 220, 424 S.E.2d at 115.

164. See *supra* note 144 and accompanying text.

165. See *supra* notes 101-109 and accompanying text.

166. *McGill*, 333 N.C. at 220-21, 424 S.E.2d at 115.

167. *Id.*

168. *McGill*, 333 N.C. at 220-21, 424 S.E.2d at 115.

169. *Id.*

sufficient to cause the reasonable person to return.¹⁷⁰ Finally, the testimony showed that cancer does not spread as fast once treatment has begun.¹⁷¹

While the court recognized Mr. McGill was told at least twice of the importance of keeping appointments, this factor did not appear to play a major role in the decision. The court came to the ultimate conclusion that whether or not Dr. French told Mr. McGill he had cancer was irrelevant.¹⁷² According to the court, if Mr. McGill had kept his scheduled appointments and followed the instructions, Dr. French would have been able to begin treatment as planned and the spreading of the cancer would have been slowed.¹⁷³ The court's analysis is counter to the analysis of courts in other jurisdictions which hold that the patient must be made aware of the importance of returning for follow-up visits.¹⁷⁴ Thus, North Carolina broadened the ability of the physician to avoid liability by allowing the contributory negligence defense even when such emphasis is not given to the importance of return visits.

Even if Dr. French told Mr. McGill to return upon the first sign of pain or other symptoms, the message to Mr. McGill would be weak unless Dr. French told him that he was diagnosed with cancer. It strains reasoning to think the emphasis of keeping appointments would have the same bearing upon the patient if he was told he had cancer as when such diagnosis was not revealed. The court did not adopt the requirement in other jurisdictions that emphasis must be given the importance of returning for follow-up care. The emphasis appears to be upon the failure to follow a doctor's instructions to return whether impressed upon the patient or not.

McGill not only opened the door to physicians to use the defense of contributory negligence in cases where the patient fails to follow instructions and return for follow-up care but also gave the defense in such actions a much broader application than other jurisdictions give it. The primary consideration in future cases

170. These symptoms experienced by Mr. McGill were not articulated in the opinion but probably related to the defendant's emphasis on the need to return. See *supra* notes 155-58 and accompanying text.

171. *McGill*, 333 N.C. at 221, 424 S.E.2d at 115.

172. *Id.*

173. *Id.*

174. See, e.g., *Lauderdale v. United States*, 666 F. Supp. 1511, 1516 (M.D. Ala. 1987) (a patient cannot be contributorily negligent in failing to return if he is not given sufficient notice that his return is essential to his well being).

will be whether or not the court really meant the decision to be read that broadly.

The court did not define when the defense was appropriate, which is consistent with other jurisdictions that determine the extent of application on a case by case basis. There appears to be a strong consensus among the members of the court shown by the lack of either dissenting or concurring opinions. Attorneys representing physicians, as well as patients, in medical malpractice actions will be on edge awaiting future cases to clarify the court's position.

V. CONCLUSION

By barring recovery in a medical malpractice action due to the patient's contributory negligence, the North Carolina Supreme Court opened the door for physicians to avoid liability for negligent conduct. *McGill* held a patient may be barred from recovering in a medical malpractice action if the patient fails to follow the physician's instructions or advice by not keeping scheduled appointments and returning as instructed. The holding marks a drastic change in position by a court which has never upheld the defense of contributory negligence in a medical malpractice action. North Carolina has fallen in line behind the majority of jurisdictions which have allowed the defense in medical malpractice actions for years.

Since the holding in this landmark decision was limited to the facts of the case, there can be no prediction on the direction the court will take with respect to the holding. The court could either broaden its application of the defense or limit it to narrow, specific situations. Only the test of future litigation will render an answer.

However, one aspect of the case which will doubtless cause future controversy, as the issue does in negligence cases outside of medical malpractice, is the complete bar to recovery. Reduction of damages appears to be a better approach than a complete bar. The patient suffers injury at the hands of the physician; however, even if the patient's negligence is miniscule, recovery is barred. The court is unlikely to change the long standing rule that contributory negligence is a complete bar to recovery and patients will suffer under it. Thus, the holding in *McGill* is likely to have two effects in the future: (1) patients will be discouraged from bringing medical malpractice actions; and (2) physicians will be encouraged now more than ever to raise the defense of contributory negligence. The shift in position by the court reflects the change in soci-

etal attitude to the physician-patient relationship but fails to reflect the societal disfavor for the contributory negligence defense.

Lucinda L. Fraley