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CONTRIBUTORY NEGLIGENCE IN MEDICAL MALPRACTICE: ARE THE STANDARDS CHANGING TO REFLECT SOCIETY'S GROWING HEALTH CARE CONSUMERISM?

I. INTRODUCTION

Medical malpractice litigation has evolved significantly in the past two decades. This evolution is the result of a perceived health care crisis, which has stimulated increased consumerism in health care issues. Due to this increasing consumer activism, the average health care consumer is more aware and better informed regarding health care issues. This comment proposes that the courts' recent assessments of contributory negligence in medical malpractice actions reflect the increased knowledge and awareness of health care consumers regarding health care issues. This change in judicial attitude is demonstrated by the courts' increasing reliance on patient behavior in determining the proximate cause of the patient's injury and rejection of the traditional requirement of concurrent negligence in proving contributory negligence.

The relationship between patient and physician is the basis for assessment of most medical negligence issues. The traditional model of the physician-patient relationship is based on the assumption that the physician has superior knowledge while the patient has little experience and information regarding health care issues. This assumption justifies the patient placing great trust in the physician's decision-making authority. Further, this assumption imposes a higher standard of care upon physicians than other tort defendants. Proving contributory negligence in a medical malpractice action based on the traditional model of the physician-patient relationship presents a difficult burden for the physician-defendant. Aside from impediments inherent in the tort system, the unique relationship between physician and patient imposes more stringent standards.

Traditionally, to prove contributory negligence in a medical malpractice action, the physician-defendant had to prove not only that the plaintiff's negligence was the proximate cause of the injury, but also that the negligence occurred simultaneously with that of the physician. Further, the physician-defendant had to prove that the patient was well-informed regarding the severity of his condition and the significance of the treatment of the condition. The requirement that a patient exercise the degree of care expected of a reasonable person under similar circumstances is profoundly affected by the effects of disease, pain,

disability, medication, and the disparity in the levels of knowledge of the patient and the physician. As a result, the patient's conduct had to be significantly unreasonable to bar recovery in medical malpractice actions based on the traditional physician-patient relationship.

This traditional model is changing. Over the past two decades, a perceived health care crisis has stimulated consumer activism in health care issues. Consumers are now more involved in and aware of medical matters. Increasing consumer awareness has had a profound effect on the physician-patient relationship. The health care consumer is no longer presumed to be totally uninformed and unaware of his health care needs. Whereas the traditional physician-patient relationship was based on the patient's blind faith in the physician's superior knowledge, health care consumers now have higher expectations of their physicians and exert more control in the decision-making process.

Recent judicial trends reflect this evolving model of the physician-patient relationship through a change in the standards applied to allegations of contributory negligence. Courts appear to be more cognizant of heightened consumer awareness of health care issues. Arguably, in response to this increased knowledge, courts are more willing to hold patients to a higher degree of responsibility for their own health care decisions. A patient's refusal to exercise due care to protect his own health needs is more likely found to be the proximate cause of the resultant harm. Accordingly, an injured patient can no longer rely on the requirement that his own negligence take place concurrently with the physician's negligence. Courts recognize that a patient's negligence subsequent to a physician's negligence can substantially affect the patient's ultimate condition.

II. Traditional Assessment of Contributory Negligence in a Medical Malpractice Action

A. Negligence in a Medical Malpractice Action

Medical malpractice is an action against a health care provider based on the assertion that the provider failed to meet the acceptable standards for delivery of health care.[1] Physicians, the health care providers most closely associated with decision-making and control, are frequently the primary focus of malpractice litigation. The most common

1. *See, e.g.*, Hall v. Hilbun, 466 So. 2d 856 (Miss. 1985). "Medical malpractice is legal fault by a [health care provider]. It arises from the failure of a [provider] to provide the quality of care required by law." *Id.* at 866.

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basis for a medical malpractice claim is negligence,[2] which requires a showing of a duty, a breach of that duty, causation and harm.[3] The burden of proving these elements is generally on the patient-plaintiff as the party seeking relief.[4]

The elements of negligence in a medical malpractice claim are: a duty based on a physician-patient relationship;[5] a recognized standard of care in the medical community; a failure by the physician to comply with that standard; and a causal connection between such failure and the injury sustained by the plaintiff.[6] To prevail, the patient must prove all of these elements. The element of causation requires that the defendant's negligence probably, rather than possibly, caused the injury.[7]

Contributory negligence is an affirmative defense asserted by the physician to show that the patient's negligence, rather than the physician's, was the cause of the patient's injury.[8] Traditionally, a defense of contributory negligence in a medical malpractice action was often unsuccessful due to the unique characteristics of the physician-patient relationship: the physician's superior knowledge, the patient's inexperience, and the high standard of care demanded of the physician.[9]

B. Traditional Model of the Physician-Patient Relationship

When applying traditional tort concepts to medical malpractice actions, the nature of the physician-patient relationship must be considered. One factor relevant to this relationship is its basis in "trust rather

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2. Kenny v. Piedmont Hosp., 222 S.E.2d 162 (Ga. 1975). "Though judgment of the culpability . . . may be more exacting than for non-medical conduct, in the common law world malpractice is . . . part of the negligence branch of the law of torts . . . which generally concerns itself with compensation of persons injured by or because of the negligent conduct of another." George H. Hauck & David W. Louisell, *Medical Malpractice*, *in* 3 ENCYCLOPEDIA OF BIOETHICS 1020, 1021 (1978).

3. W. PAGE KEETON et al., PROSSER AND KEETON ON THE LAW OF TORTS § 30, at 164-65 (5th ed. 1984).

4. Newell v. Corres, 466 N.E.2d 1085, 1089 (Ill. App. Ct. 1984); Todd v. Eitel Hosp., 237 N.W.2d 357, 359 (Minn. 1975).

5. *See* RESTATEMENT (SECOND) OF TORTS §§ 323-24 (1979). Liability may result from substandard care where one undertakes to render services, which he should recognize are necessary to protect the safety of another, and his failure to exercise due care increases the other's risk of harm or the harm is suffered because the other relied on the undertaking. *Id.* Section 324 recognizes that one who takes charge of another who is helpless may be liable for bodily harm caused by failure to exercise reasonable care to secure the other's safety while in the actor's charge or by leaving the other in a worse position than before by discontinuing aid. *Id.* § 324.

6. Bruni v. Tatsumi, 346 N.E.2d 673, 676 (Ohio 1976); *see also* Kosberg v. Washington Hosp. Center, Inc., 394 F.2d 947, 949 (D.C. Cir. 1968); Almond v. Nugent, 34 Iowa 300, 301 (1872); *Todd*, 237 N.W.2d at 359.

7. *See Newell*, 466 N.E.2d at 1089; Cooper v. Sisters of Charity of Cincinnati, Inc., 272 N.E.2d 97, 103 (Ohio 1971); Kuhn v. Banker, 13 N.E.2d 242, 247 (Ohio 1938).

8. *See infra* notes 43-54 and accompanying text.

9. *See infra* notes 87-142 and accompanying text.

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than on the monetary considerations evident in the more typical business transaction."[10] Since a patient is expected to place his full trust in a physician, he is not expected to question his physician's advice.[11] A patient's justified reliance on a physician's judgment results in a higher standard of care being applied to defendants in medical malpractice actions than is applied to defendants in other tort relationships.[12]

Further, since health care is such a complex and mercurial science, each technological development affects the appropriate and accepted standard of medical care.[13] A physician must remain fully informed of the current state of technology to meet acceptable standards of professional care.[14] Failure to remain informed of technological changes affects the physician's performance relevant to the accepted standard of care, and violates the trust the patient places in the physician.

The practice of medicine requires extensive education and experience. The physician's superior knowledge of medical matters justifies holding her to an exacting standard of care.[15] There is an "apparent belief that [medical] professionals should be measured by a higher standard of performance than others. Where lives and health are clearly at stake, acts of medical negligence . . . tend to shock the public conscience to an even greater degree than do similar acts of other professionals."[16]

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10. George J. Annas, *Patient's Rights Movement, in* 3 ENCYCLOPEDIA OF BIOETHICS 1201, 1201 (1978).

11. *See, e.g.*, Mikkelsen v. Haslam, 764 P.2d 1384 (Utah 1988). The physician-patient relationship permits patient reliance on the physician's advice. It is not contributory negligence or assumption of risk to rely on the physician's advice without distrusting the physician or checking with other physicians. *Id.* at 1388; *see also* Lawrence v. Wirth, 309 S.E.2d 315 (Va. 1983). "Due to the great disparity in medical knowledge between doctor and patient, the patient is entitled to rely upon assurances made by the doctor . . . ." *Lawrence*, 309 S.E.2d at 317 (citation omitted).

12. *See, e.g.*, Bird v. Pritchard, 291 N.E.2d 769 (Ohio 1973). The court noted that " 'the general rules relating to contributory negligence must be sharpened considerably when applied to medical malpractice cases.' " *Id.* at 772 (quoting Flynn v. Stearns, 145 A.2d 33, 37 (N.J. 1958)).

13. *See* Burton v. Brooklyn Doctors Hosp., 452 N.Y.S.2d 875 (1982). The defendant used the accepted standard of care in administering oxygen to a premature infant. The court held that the physician could not be freed from liability for adhering to the accepted standard of care when sufficient studies had been published to indicate that the accepted standard of care was no longer the most appropriate method of treatment. *Id.* at 879.

14. *See generally* Morrison v. MacNamara, 407 A.2d 555, 560-65 (D.C. Cir. 1979).

15. *See, e.g.*, Martineau v. Nelson, 247 N.W.2d 409, 417 (Minn. 1976). In an action for medical malpractice and breach of warranty alleging a physician's negligence, different doctors had given conflicting opinions as to the effectiveness of a procedure. *Id.* The jury found each party 50% negligent. *Id.* On appeal, the court held that the plaintiff could not be held equally negligent with the physicians since the negligence involved interpretation of medical matters about which doctors owe a greater duty than a patient owes to himself. *Id.* The superior knowledge and skill of the physicians should have been reflected in complete and accurate advice, and the patient should not [illegible] distinguish appropriate from inappropriate advice. *Id.*

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16. Hauck & Louisell, *supra* note 2, at 1021.

Courts traditionally relied on the physician's extensive education and the high standard of care to understand the great degree of trust a patient places in the physician's decision-making authority.[17] Patients have been presumed to have limited experience, maturity, knowledge and appreciation of health care issues.[18] Courts relying on the traditional physician-patient relationship emphasized the fact that the patient was unlikely to have any special knowledge of his illness and thus, relied on the physician's superior knowledge.[19]

To maintain a defense of contributory negligence, the courts required the physician to show that the plaintiff was well-informed and aware of the significance of his condition and the relevant treatments of the condition.[20] Courts were unwilling to acknowledge that the health care consumer could be generally well-informed of health care issues. The Maryland Court of Appeals noted that:

> [I]n discussing contributory negligence in medical malpractice cases, courts have noted the disparity between the knowledge and skill of a doctor and that of a patient. The patient is not in a position to diagnose his own ailment. Without being told, he does not know the risks of medication. He is not in a position to judge whether the prescribed course of treatment is in his best interest. As a consequence, it is not contributory negligence for a patient to follow a doctor's instructions or rely on his advice.[21]

Considerations of the specialized knowledge of physicians and the presumed limitations of patients' awareness of health care issues, therefore, contribute to the high standards of care attributed to physicians.[22]

A factor related to the high standards of care attributed to physicians is the nature of the harm which results from negligent conduct in a physician-patient relationship. Compensation for non-economic harm

17. *See, e.g.*, Lawrence v. Wirth, 309 S.E.2d 315 (Va. 1983). A physician failed to diagnose a malignancy in a patient's breast, but advised the patient to return if any further changes were noted. The court held that the patient was justified in her delay in seeking medical care when the size of the breast lump increased because she was frightened by the possible diagnosis of cancer and trusted the judgment of the physician. *Id.* at 318.

18. *Morrison*, 407 A.2d at 567-68.

19. *Martineau*, 247 N.W.2d at 417 (superior knowledge and skill of physician should have been reflected in complete and accurate advice); *Lawrence*, 309 S.E.2d at 318 (patient justified in relying on physician even though symptoms should have given notice of potential problems).

20. *See, e.g.*, *Martineau*, 247 N.W.2d at 416-17 (contributory negligence not appropriate since no evidence indicated that the patient was aware of the risk); *see also* Sawka v. Prokopowycz, 306 N.W.2d 354 (Mich. Ct. App. 1981).

21. Santoni v. Moodie, 452 A.2d 1223, 1228 (Md. Ct. Spec. App. 1982) (citations omitted).

22. John O. Beahrs, *Legal Duties of Psychiatric Patients*, 18 BULL. AM. ACAD. PSYCHIATRY L. 189, 190 (1990); *see also Morrison*, 407 A.2d at 567-68.

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is more ambiguous than compensation for economic injury.[23] "Damages are often rough approximations."[24] This phrase is exemplified by the difficulties juries have in determining the appropriate compensation for the loss of a limb or an eye.[25] Due to the emotional and sympathetic nature of the injury and the desire to afford some compensation to the injured party, courts are willing to find that negligence exists where no actual proof of fault is found.[26]

Another burden the physician-defendant must confront derives from the general tort concept that a plaintiff must be capable of exercising the care of a reasonable person in similar circumstances.[27] The reasonable person standard is particularly at issue in a medical malpractice action because patients are frequently in compromised circumstances due to sedation, mental incapacitation, or physical condition.[28] "A usually intelligent, rational person may lose all of his rationality and most of his sense when he becomes ill."[29] Thus, factors relevant to the traditional physician-patient relationship, including the superior knowledge attributed to the physician, the patient's perceived justified reliance on that superior knowledge, the emotional nature of a medical

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23. Hauck & Louisell, *supra* note 2, at 1021-22.

24. *Id.* at 1022.

25. *Id.*

26. *Id.* Res ipsa loquitur is one example of the courts' efforts to compensate injured patients. Res ipsa loquitur translates to "the thing speaks for itself." *Id.* The doctrine is utilized where the plaintiff is unable to prove the causation of the injury, but the injury is one that could only occur from the malpractice or negligence of specific defendants. KEETON et al., *supra* note 3, § 39. It creates a rebuttable presumption that malpractice was committed by requiring the defendant to show that malpractice was not committed. *Id.* § 40; *see, e.g.*, Lair v. Lancourt, 734 S.W.2d 247 (Mo. Ct. App. 1987) (applying the doctrine of res ipsa loquitur). *But see* Mulcahy v. Eli Lilly & Co., 386 N.W.2d 67 (Iowa 1986) (reasoning that application of res ipsa loquitur in questionable situations is an abuse of the tort system, spreading the ultimate damages to all health care consumers). For further information on res ipsa loquitur, see KEETON et al., *supra* note 3, §§ 39-40. For another example of the court bending accepted legal principles to compensate injured patients, see *Anderson v. Somberg*, 338 A.2d 1 (N.J.), *cert. denied*, 423 U.S. 929 (1975) (shifting the burden to the defendant doctors to show non-negligence).

27. RESTATEMENT (SECOND) OF TORTS § 463 (1979).

28. *See, e.g.*, Clark v. Piedmont Hosp. Inc., 162 S.E.2d 468, 470 (Ga. Ct. App. 1968) (barring a defense of contributory negligence against an elderly patient who fell getting out of bed due to old age and illness); Simpson v. Davis, 549 P.2d 950, 957 (Kan. 1976) (refusing to apply the defense of contributory negligence to a conscious but partially anesthetized patient); Steele v. Woods, 327 S.W.2d 187, 198 (Mo. 1959) (refusal of treatment due to pain and sedation not contributory negligence).

29. Angela Holder, *Contributory Negligence—Part 3*, 218 JAMA 1109, 1109 (1971); *see also* Cowan v. Doering, 545 A.2d 159, 163 (N.J. 1988) (holding that "a mentally disturbed plaintiff is not capable of adhering to a reasonable person's standard of self-care, but . . . that plaintiff [is] responsible for the consequences of conduct that is unreasonable in light of the plaintiff's capacity"); Rogers v. Baptist Gen. Convention, 651 P.2d 672, 676 (Okla. 1982) ("hospital must take into account the physical and mental condition of patients on an individual basis").

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injury, and the compromised state of many patients, resulted in a higher standard of care being applied to physicians' conduct.[30]

C. *A Medical Malpractice Claim Based on the Traditional Model of the Physician-Patient Relationship*

1. The Element of Causation

Distinguishing between the negligence of the physician and the contributory negligence of the patient is ultimately a question of causation. Causation is one of the most complex and difficult elements to comprehend in a tort action. Understanding causation is particularly difficult in a medical malpractice action because a medical negligence claim generally involves several unique issues: a pre-existing illness or injury; alleged negligence of a physician; and some degree of responsibility on the part of a patient for self-care following the intervention of the physician. It is sometimes difficult to separate these factors for purposes of determining the proximate cause of the patient's injury.[31]

Determination of causation in contributory negligence in a medical malpractice action depends upon the application of the following doctrines: proximate cause; contributory and comparative negligence; and, less significantly, the doctrines of assumption of risk, avoidance of the consequences, and last clear chance. The following subsections will briefly describe the elements of each of these doctrines.

a. The Doctrine of Proximate Cause[32]

To analyze a claim of contributory negligence, courts must consider the causation of injury, and more specifically, the proximate causation of injury.[33] Proximate cause is defined as " 'any cause which in

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30. Leslie J. Miller, *Comparative Negligence*, 248 JAMA 1443, 1444 (1982).

> Courts have often been reluctant to apply the doctrine of contributory negligence because it can preclude recovery by a person whose negligence is substantially less than that of the person being sued. This is particularly true in professional liability actions due to the great disparity in medical knowledge between the patient and the physician. Thus, the defense of contributory negligence has been successful mainly in cases where the patient's conduct shows flagrant disregard for his own health or safety.

Id.

31. Speed v. State, 240 N.W.2d 901 (Iowa 1976) (applying the substantial factor test and requiring that it appear more probable than not that, had the physician exercised due care, the treatment would have been a success and the injury avoided).

32. For further information on proximate cause, see KEETON et al., *supra* note 3, §§ 41-45.

33. Bird v. Pritchard, 291 N.E.2d 769, 771 (Ohio Ct. App. 1973).

> Contributory negligence is not a defense in an ordinary tort action unless that negligence is a direct and proximate cause of the injury received . . . . [F]or contributory negligence to defeat the claim of the plaintiff, there must be not only negligent conduct by the plaintiff but also a direct and proximate causal relationship between the negligent act and the injury the plaintiff received.

Id. (quoting Bahm v. Pittsburg & Lake Erie Rd. Co., 217 N.E.2d 217, 220 (Ohio 1966)).

the natural and continuous sequence, unbroken by an efficient intervening cause, produces the result complained of and without which the result would not have occurred.' "[34] Proximate cause implies that the injuries would not have occurred without the conduct of the actor.[35]

It is necessary to distinguish contributory negligence from proximate cause.[36] Although a finding that the patient's conduct was a proximate cause of the injury is necessary to establish contributory negligence, proximate cause alone is not sufficient.[37] It also must be established that the causal relationship was the product of the patient disregarding his duty to act reasonably in regard to his own health and well-being. As a result, it is important to "make clear that the standard of conduct required of [a] plaintiff to avoid contributory negligence [is] that of a reasonably prudent person under similar circumstances."[38]

In *Ayoub v. Spencer*, the Third Circuit held that the district court's jury instructions had "intertwined" the issues of contributory negligence and proximate cause, possibly causing the jury to base its verdict for the defendant on proximate cause "without regard for the reasonableness of [the plaintiff's] conduct."[39] The court feared that the issues had been so unclear to the jury that they may have found "contributory negligence based solely upon proximate cause."[40] To support a defense of contributory negligence, therefore, the defendant must show not only that the plaintiff's actions were the proximate cause of the injury, but also that the plaintiff's conduct was so unreasonable that the plaintiff's actions could be considered negligent.[41]

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34. Ostrowski v. Azzara, 545 A.2d 148, 153 (N.J. 1988) (quoting Fernandez v. Baruch, 232 A.2d 661 (N.J. Super. Ct. App. Div. 1967), *rev'd on other grounds*, 244 A.2d 109 (N.J. 1968)).

35. KEETON et al., *supra* note 3, § 41; *see also Ostrowski*, 545 A.2d at 153. "If the injury or loss were to occur in the absence of a physician's negligence or malpractice, then before responsibility may be visited upon the defendant the negligent conduct or malpractice must have been shown to have been a substantial factor in causing the harm." *Id.* (citation omitted).

36. Ayoub v. Spencer, 550 F.2d 164, 168 (3d Cir.), *cert. denied*, 432 U.S. 907 (1977). A new trial was ordered since the jury may have equated contributory negligence with proximate cause. The appellate court noted that the district court had instructed the jury that the plaintiff's failure to seek medical treatment was a substantial factor in bringing about the injury, but had failed to instruct the jury in assessing whether the plaintiff's conduct was unreasonable, which is a prerequisite to contributory negligence. *Id.*

37. *Id.*

38. *Id.* (footnote omitted).

39. *Id.*

40. *Id.* at 169 (citation omitted); *see also* Ostrowski v. Azzara, 545 A.2d 148, 157 (N.J. 1988). "[B]efore submitting the issue to the jury, a court should carefully scrutinize the evidence to see if there is a sound basis in the proofs for the assertion that the post-treatment conduct of the patient was indeed a significant cause of the increased damages." *Ostrowski*, 545 A.2d at 157.

41. *Ayoub*, 550 F.2d at 169. One can act unreasonably without causing harm. Conversely, an injury may result from a reasonable act.

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b. Contributory Negligence[42]

Contributory negligence is defined as conduct by the plaintiff which falls below the standard to which the plaintiff should conform for his own protection and which is a legally contributing cause of the plaintiff's harm.[43] Generally, the standard is that of a reasonably prudent person under similar circumstances.[44] It is assumed that a reasonable person will take whatever reasonable measures are necessary to prevent personal injury.[45] To be contributorily negligent, a person must actually have been aware of or should have been aware of the risks involved and then failed to exercise reasonable and ordinary care for his own safety.[46] Contributory negligence is a determination that the plaintiff's negligence, combined with that of the defendant's, brought about the plaintiff's injury.[47] Determining each party's respective level of fault is the focus of contributory negligence litigation.[48] Generally, to bar recovery, the plaintiff's negligence " 'must have been an active and efficient contributing cause of the injury; it must have been simultaneous and co-operating with the fault of the defendant, must have entered into the creation of the cause of action, and have been an element in the transaction which constituted it.' "[49] In most circumstances, the defendant has the burden of proving that the plaintiff was contributorily negligent.[50]

The consequences of proving that a patient was contributorily negligent can be harsh. Even if negligence on the part of the physician is

42. For further information on contributory negligence, see KEETON et al., *supra* note 3, § 65.

43. Baxley v. Rosenblum, 400 S.E.2d 502 (S.C. Ct. App. 1991).

44. Greer Lines Co. v. Roberts, 139 A.2d 235, 239 (Md. 1958).

45. *Id.*

> [T]he law places upon one the duty of exercising reasonable care for his own protection under any and all circumstances, but this requirement of the law is little more than what is naturally practiced under the instinct of self-preservation. What an ordinarily prudent and careful person would do under a given set of circumstances is usually controlled by the instinctive urge [of one] to protect himself from harm.

Id. at 239 (citation omitted).

46. *Id.*

47. Ostrowski v. Azzara, 545 A.2d 148, 151 (N.J. 1988); *Baxley*, 400 S.E.2d at 506.

48. *Ostrowski*, 545 A.2d at 151. "Fault in that context meant a breach of a legal duty that was comparable to the duty of the other actors to exercise such care in the circumstances as was necessary to avoid the risk of injury incurred." *Id.*

49. Rochester v. Katalan, 320 A.2d 704, 707 (Del. 1974) (quoting 41 AM. JUR., *Physicians and Surgeons* § 80 (1942)).

50. Tish v. Welter, 70 Ohio N.P. 472 (C.P. Knox 1897); *see also* Fall v. White, 449 N.E.2d 628 (Ind. Ct. App. 1983) (defendant has the burden of proof for contributory negligence in medical malpractice actions). *But see* Robinson & Weaver v. Gary, 28 Ohio St. 241, 250 (1876). Where the plaintiff's case raises the issue of contributory negligence, the plaintiff may be required to disprove that he was negligent before he can assert that the defendant was negligent. It becomes a question of fact for the jury. *Id.*

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proven, the traditional contributory negligence doctrine holds that any negligence on the part of the patient completely bars him from any recovery.[51] It makes no "difference that one of the parties contributed in a much greater degree."[52] To recover, the plaintiff "must not have contributed at all."[53] These harsh consequences caused a number of states to replace the doctrine of contributory negligence with the doctrine of comparative negligence.[54]

c. Comparative Negligence[55]

Comparative negligence embodies the concept of holding a plaintiff responsible for his wrongful conduct.[56] Under the comparative negligence theory, negligence by the plaintiff results in a reduction of the plaintiff's damage award rather than completely barring the plaintiff's recovery.[57] The doctrine of comparative negligence requires that the trier of fact determine the relative percentage of negligence attributable to each party and adjust the damage assessment accordingly.[58]

Generally, depending on the individual state's statute or common law, the doctrine of comparative negligence is a complete bar to the

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51. ANGELA R. HOLDER, MEDICAL MALPRACTICE LAW 302 (1978).

52. Geiselman v. Scott, 25 Ohio St. 86, 88 (1874).

53. *Id.*

54. *See, e.g.*, OHIO REV. CODE ANN. § 2315.19 (Anderson 1990). Section 2315.19(A)(2) provides in pertinent part:

> Contributory negligence . . . of a person does not bar the person or his legal representative as complainant from recovering damages that have directly and proximately resulted from the negligence of one or more other persons, if the contributory negligence . . . of the complainant or of the person for whom he is legal representative was no greater than the combined negligence of all other persons from whom the complainant seeks recovery.

Id.

55. For further information on comparative negligence, see KEETON et al., *supra* note 3, § 67.

56. *Id.*

57. Ostrowski v. Azzara, 545 A.2d 148, 151 (N.J. 1988).

> Comparative negligence was intended to ameliorate the harshness of contributory negligence but should not blur its clarity. It was designed only to leave the door open to those plaintiffs whose fault was not greater than the defendant's, not to create an independent gate-keeping function. Comparative negligence, then, will qualify the doctrine of contributory negligence when that doctrine would otherwise be applicable as a limitation on recovery.

Id.

58. MILES J. ZAREMSKI & LOUIS S. GOLDSTEIN, MEDICAL AND HOSPITAL NEGLIGENCE § 32:22 (1988). Applying this concept, where a patient is found to be liable for thirty percent of the injury, and the physician seventy percent liable, the trier of fact would determine the total amount of damages and subtract thirty percent from the patient's total recovery. KEETON et al., *supra* note 3, § 67.

plaintiff's recovery only if the trier of fact determines that the negligence of the plaintiff exceeds a certain percentage.[59] Also, as at common law, the plaintiff may not recover if the injury was caused solely by his own negligence without any fault on the part of the defendant.[60] Finally, analysis of proximate cause is as necessary for assessment of comparative negligence as it is for contributory negligence.

d. Assumption of Risk[61]

Traditionally, a defense of assumption of risk was rarely sustained in medical malpractice actions.[62] Assumption of risk was only appropriate where the hazards were so obvious that the patient should have been aware of them.[63] Although pure assumption of risk theory assumes no negligence on the part of the defendant,[64] the doctrine may be considered in contributory negligence analysis since the plaintiff may have deliberately and voluntarily chosen to assume the risk of harm.[65] Deliberate and voluntary choice implies that the patient understands the possibility of a negative result and knowingly consents to the treatment.[66]

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59. ZAREMSKI & GOLDSTEIN, *supra* note 58, § 32:22. For example, under Ohio Revised Code section 2315.19, the comparative negligence statute, when the trier of fact determines that the plaintiff was 51% negligent, he is barred from recovering for the 49% negligence of the defendant. OHIO REV. CODE ANN. § 2315.19 (Anderson 1990).

60. Robinson & Weaver v. Gary, 28 Ohio St. 241 (1876).

61. Assumption of risk is qualified by type, which includes express, primary, and secondary. KEETON et al., *supra* note 3, § 68. Secondary assumption of risk is conceptually related to contributory negligence, defined as "(1) [plaintiff's] consent to or acquiescence in (2) an appreciated or known (3) risk." Wever v. Hicks, 228 N.E.2d 315, 318 (Ohio 1967) (citation omitted). The defendant owes a duty to the plaintiff, but the plaintiff's awareness of the risk acts as a defense. The unreasonable conduct of the plaintiff defines his negligence. Siglow v. Smart, 539 N.E.2d 636, 638 (Ohio Ct. App. 1987). Although secondary assumption of risk acknowledges the potential for injury, it is not a consent to injury. Thus, it resembles contributory negligence, and generally involves factual questions to be resolved by the jury. Anderson v. Ceccardi, 451 N.E.2d 780, 782 (Ohio 1983); *see also* Meistrich v. Casino Arena, 155 A.2d 1208 (N.J. 1959); KEETON et al., *supra* note 3, § 68.

62. In order for assumption of risk to apply in a medical malpractice action, all the resulting injuries must have been carefully explained to the patient. "Since most patients' knowledge of medicine does not permit them to understand these risks, without clear proof of totally informed consent, the defense of assumption of risk is not successful." HOLDER, *supra* note 51, at 310.

63. Champs v. Stone, 58 N.E.2d 803, 805 (Ohio Ct. App. 1944) (assumption of risk appropriate when patient allowed an obviously intoxicated physician to administer an injection); Charrin v. Methodist Hosp., 432 S.W.2d 572, 575 (Tex. Ct. App. 1968) (the patient assumed the risk when she tripped over an electrical cord in her hospital room).

64. KEETON et al., *supra* note 3, § 68.

65. Baxley v. Rosenblum, 400 S.E.2d 502, 506-07 (S.C. Ct. App. 1991) (although physician negligently failed to diagnose the patient's illness, patient's failure to report obvious symptoms led court to find that patient assumed the risk of the ultimate injury).

66. *Id.*

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Assumption of risk requires proof of three elements: a condition which is "patently dangerous"; full knowledge of the condition; and voluntary exposure to the potential harm.[67] The person who voluntarily exposes himself to a known risk of harm should not be allowed to hold another person responsible for the unwanted results of his own choice.[68]

Assumption of risk in a medical malpractice action is intertwined with the doctrine of informed consent.[69] Informed consent requires that all the risks of treatment or lack of treatment be explained to the patient. In the absence of such an explanation, the patient's consent for treatment cannot be considered effective. If treatment results in harm to the patient, and such harm was not described to the patient prior to his giving consent for the treatment, the doctrine of assumption of risk is inapplicable.[70] "Since most patients' knowledge of medicine does not permit them to understand these risks, without clear proof of totally informed consent, the defense of assumption of risk is not successful."[71] Only in rare circumstances would a patient be considered to have assumed the risk of negligent medical treatment.[72]

e. The Doctrine of Avoidable Consequences[73]

Traditionally, the negligence of a patient subsequent to a negligent act by a physician would not serve as a defense for the negligent physician.[74] Generally, the patient's subsequent negligence would invoke the

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67. Briere v. Lathrop Co., 258 N.E.2d 597, 603 (Ohio 1970); Siglow v. Smart, 539 N.E.2d 636, 638 (Ohio Ct. App. 1987).

68. *Baxley*, 400 S.E.2d at 506.

69. Faile v. Bycura, 374 S.E.2d 687 (S.C. Ct. App. 1988). The concepts of informed consent and assumption of risk are easily confused. A lack of informed consent alleges that "a medical practitioner failed to inform [the patient] of the consequences of a procedure . . . . This is a theory of liability. In such a situation, a plaintiff must normally establish a breach of the duty to disclose by expert testimony." *Id.* at 688 (citations omitted).

70. HOLDER, *supra* note 51, at 310.

71. *Id.*

72. The District of Columbia Court of Appeals has noted that:

> In the context of medical malpractice, the superior knowledge of the doctor with his expertise in medical matters and the generally limited ability of the patient to ascertain the existence of certain risks and dangers that inhere in certain medical treatments, negates the critical elements of the defense, i.e., knowledge and appreciation of the risk. Thus, save exceptional circumstances, a patient cannot assume the risk of negligent treatment.

Morrison v. MacNamara, 407 A.2d 555, 567-68 (D.C. Cir. 1979) (citation omitted). The court said that the same principles would apply to contributory negligence. *Id.* at 568 n.11; *see also* Shorter v. Drury, 695 P.2d 116 (Wash.), *cert. denied*, 427 U.S. 827 (1985). Subsequent to a physician's negligence, a Jehovah's Witness refused a necessary blood transfusion and died. *Shorter*, 695 P.2d at 116. The court found the patient 75% negligent and the physician 25% negligent. Where the patient may have assumed the risk of injury by refusing to accept the transfusion, she did not assume the risk of negligent treatment by the physician. *Id.*

73. For further information on the doctrine of avoidable consequences, see KEETON et al., *supra* note 3, § 65.

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74. Carpenter v. Blake, 75 N.Y. 12 (1878) (negligence of the plaintiff or of another physician subsequent to that of the defendant physician will not discharge the cause of action).

doctrine of avoidable consequences, and serve only to mitigate the plaintiff's damages.[75] Although the doctrine of avoidable consequences may be more applicable in damage assessment than in fault evaluation, public policy requires its consideration in evaluating a claim of contributory negligence.[76]

The doctrine of avoidable consequences states "that a plaintiff who has suffered an injury as the proximate result of a tort cannot recover for any portion of the harm that by the exercise of ordinary care he could have avoided."[77] The doctrine of avoidable consequences can be easily distinguished from contributory negligence. The doctrine of avoidable consequences is appropriate when the negligence of the plaintiff occurred subsequent to that of the defendant; contributory negligence requires simultaneous negligence of both parties.[78]

A plaintiff's negligent conduct is not immunized by the doctrine of avoidable consequences. It diminishes the damages rather than abolishing the cause of action for negligence.[79] Where the doctrine of avoidable consequences is applicable, the person bringing the suit is not contributorily negligent since his actions were not a proximate cause of the

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75. Ostrowski v. Azzara, 545 A.2d 148, 151 (N.J. 1988).

76. *See* RESTATEMENT (SECOND) OF TORTS § 918 cmt. a (1979). The comment discusses the doctrine of avoidable consequences:

> [I]t is not true that the injured person has a duty to act, nor that the conduct of the tortfeasor ceases to be a legal cause of the ultimate harm; but recovery for the harm is denied because it is in part the result of the injured person's lack of care, and public policy requires that persons should be discouraged from wasting their resources, both physical or economic.

Id.

77. *Ostrowski*, 545 A.2d at 151 (citations omitted); *see also* Hagerty v. L & L Marine Servs., Inc., 788 F.2d 315, 319 (5th Cir. 1986) ("under the 'avoidable consequences rule,' [a claimant] is required to submit to treatment that is medically advisable; failure to do so may bar future recovery for a condition he could thereby have alleviated or avoided"); KEETON et al., *supra* note 3, § 65.

78. *Ostrowski*, 545 A.2d at 152.

79. *Id.* at 154.

> The doctrine of contributory negligence bars any recovery to the claimant whose negligent action or inaction *before* the defendant's wrongdoing has been completed has contributed to cause actual invasion of plaintiff's person or property. By contrast, "[t]he doctrine of avoidable consequences comes into play at a later stage. Where the defendant has already committed an actionable wrong, whether tort or breach of contract, then this doctrine [avoidable consequences] limits the plaintiff's recovery by disallowing only those items of damages which could reasonably have been averted . . . . [C]ontributory negligence is to be asserted as a complete defense, whereas the doctrine of avoidable consequences is not considered a defense at all, but merely a rule of damages by which certain particular items of loss may be excluded from consideration . . . ."

Id. (citation omitted) (quoting CHARLES T. MCCORMICK, MCCORMICK ON DAMAGES ch. 5, at 127-28 (1935)).

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original injury.[80] Thus, recovery is reduced to the extent that the injured person aggravated the injury.[81]

f. The Doctrine of Last Clear Chance[82]

Another consideration in medical malpractice is the doctrine of last clear chance. Last clear chance requires that "a person who has negligently placed himself in a position of danger may nevertheless recover damages if the person being sued discovered the danger while there was still time to avoid the injury and failed to do so."[83] For a plaintiff to assert the last clear chance doctrine, he must show that the defendant was aware of the plaintiff's impending harm.[84] The doctrine is not appropriate in all situations where contributory negligence is at issue, but "only where the plaintiff's antecedent negligence has become remote in the chain of causation and is but a mere condition of the plaintiff's injury."[85]

The last clear chance doctrine is distinguishable from the traditional application of contributory negligence. In the former, the plaintiff's negligence must occur prior to that of the defendant; while in the latter, the plaintiff's negligence must occur simultaneously with that of the defendant.[86]

80. KEETON et al., *supra* note 3, § 65.

81. *Id.*

82. For more information on the doctrine of last clear chance, see RESTATEMENT (SECOND) OF TORTS §§ 479-80 (1979).

83. Miller, *supra* note 30, at 1443-44; *see also* Mackey v. Greenview Hosp., Inc., 587 S.W.2d 249 (Ky. Ct. App. 1979) (considering but denying application of last clear chance since the physician could not have discovered the danger while there was time to avoid the injury).

84. Johnston v. Ward, 344 S.E.2d 166, 172 (S.C. Ct. App. 1986).

85. *Id.* (quoting Smith v. Blackwell, 156 S.E.2d 867 (S.C. 1967)).

> "[The doctrine of last clear chance] does not apply where the plaintiff's act combines and concurs with the defendant's act as a proximate cause of the injury." Before the doctrine can be applied, the plaintiff's negligence must have ceased to operate as a proximate cause of the injury while there was still time for the defendant's negligence to intervene.

Id. at 173 (citation omitted) (quoting Brown v. George, 294 S.E.2d 35, 36 (S.C. 1982)).

86. Another cause of action relevant to a medical malpractice action is the loss of chance doctrine. Although not related to contributory negligence, it is a significant factor in determining damages where the patients present themselves to the physician in a compromised state. Under the loss of chance theory, the plaintiff already has a shortened life expectancy and the defendant's negligence has decreased the chance of survival. The burden should fall on the plaintiff to prove what the chance was worth. If the chance was better than even, the plaintiff should probably be fully compensated for the difference between his actual condition and his condition had the treatment been successful. However, where the chance of survival is less than even, the patient should recover only for that chance of recovery that would have existed without the defendant's negligence. *See generally* KEETON et al., *supra* note 3, § 66. Thus, a patient with only a nine percent chance of survival prior to the physician's negligence should be accorded damages only for value of the lost nine percent chance of survival. *See, e.g.*, Chester v. United States, 403 F. Supp. 458 (W.D. Pa. 1975), *aff'd without op.*, 546 F.2d 415 (3d Cir. 1976).

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2. Application of Related Doctrines in a Traditional Medical Malpractice Action

Courts following the model of the traditional physician-patient relationship held only on limited situations that a patient's negligence was a contributing factor to the injury sustained. Similarly, doctrines such as comparative negligence and assumption of risk were narrowly construed in a medical malpractice action. Courts developed strict guidelines requiring a clear finding that the patient's and the physician's negligence were concurrent, and that the patient's act was the proximate cause of his injury. The following section reviews earlier cases, demonstrating the courts' emphasis on concurrent negligence and proximate cause in contributory negligence analysis.

a. Concurrent Negligence

Traditionally, the courts have rigidly held the defendant to the burden of proving that the negligence of the patient occurred simultaneously with that of the physician.[87] When the patient's negligence occurred prior to that of the physician, analysis similar to that used with the doctrine of the particularly susceptible victim prevented the patient from being held liable for the resultant injury.[88] In *Whitehead v. Linkous*,[89] the Florida District Court of Appeals refused to give a jury instruction on contributory negligence where a patient's intentional overdose on medication and alcohol resulted in the patient's death.[90] Since the patient's behavior occurred prior to the physician's negligence, the patient's conduct was not the proximate cause of the injury.[91]

Similarly, if the patient's negligence occurred subsequent to the physician's negligence, it merely added to the effect of the defendant's

87. *See, e.g.*, Jenkins v. Charleston Gen. Hosp. & Training School, 110 S.E. 560 (W. Va. 1922) (explaining concurrent and subsequent negligence). "[T]o be contributory, [the] negligence must be contemporaneous with the main fact charged as negligence, and . . . the patient's negligence after dismissal of the physician or his abandonment of the case, does not bar recovery for the negligence of the [physician], committed before termination of the relation." *Id.* at 563.

88. The "doctrine of the particularly susceptible victim" suggests that the defendant must take the plaintiff as she finds him. When a patient initially presents himself to the physician in a debilitated condition, the physician cannot later accuse the patient of contributing to his own injury due to that debilitated condition. *See, e.g.*, Ostrowski v. Azzara, 545 A.2d 148, 149 (N.J. 1988). "[A] physician must exercise the degree of care commensurate with the needs of the patient as she presents herself. This is but another way of saying that a defendant takes the plaintiff as she finds her." *Id.*

89. 404 So. 2d 377 (Fla. Dist. Ct. App. 1981).

90. *Id.* at 379-80.

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negligence, and was considered under the doctrine of avoidable consequences rather than under the doctrine of contributory negligence.[92] In this situation, the patient's negligence was not considered the cause of his injuries, and thus, did not relieve the physician of liability. Subsequent negligence of the patient merely served to decrease the amount of damages available to the patient.[93]

In *Sawka v. Prokopowycz*,[94] for example, the patient, complaining of respiratory problems, refused to quit smoking on the physician's instructions.[95] Although the physician failed to diagnose cancer, he instructed the patient that smoking would exacerbate the condition.[96] The Michigan Court of Appeals found that the patient was not contributorily negligent since his conduct was not concurrent with that of the physician, and thus not the proximate cause of the injury.[97]

It could be assumed that only in limited instances would a defense of contributory negligence be appropriate in a medical malpractice action. "Negligence concurrent with medical treatment is extremely unusual, because the patient is usually inactive at that time."[98] One rare example where the patient's negligence was contemporaneous with that of the physician occurred in *Champs v. Stone*.[99] The Ohio Court of Appeals found a patient to be contributorily negligent when he allowed an obviously intoxicated physician to administer an injection.[100] In most circumstances, however, the burden imposed upon the physician of showing that the patient's conduct occurred simultaneously with the physician's negligent act is rarely met.

b. Proximate Cause

Narrow construction of the doctrine of proximate cause is the second guideline developed by courts following the model of the traditional physician-patient relationship. This narrow construction led courts to find that a patient's own negligence was a contributing factor to his injury in only limited situations.

This subsection considers those circumstances in which a court following the traditional model of the physician-patient relationship most

92. *See supra* text accompanying notes 73-81.

93. *See, e.g.*, Beadle v. Paine, 80 P. 903 (Or. 1905). Failure to follow the physician's advice subsequent to negligent treatment "could only serve to mitigate the damages . . . but not to relieve against the primary liability." *Id.* at 906.

94. 306 N.W.2d 354 (Mich. Ct. App. 1981).

95. *Id.* at 357.

96. *Id.*

97. *Id.*

98. Holder, *supra* note 51, at 302.

99. 58 N.E.2d 803 (Ohio Ct. App. 1944).

100. *Id.*

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often found contributory negligence on the part of a patient. These situations occurred where the patient failed to follow the physician's instructions,[101] refused suggested treatment,[102] or gave false, incomplete, or misleading information concerning symptoms.[103] Even in these limited situations, courts were often willing to distinguish the circumstances in order to deny a defense of contributory negligence.

A patient's failure to follow a physician's advice was held to have contributed to his ultimate injury in *Stacy v. Williams*.[104] In *Stacy*, the Kentucky Supreme Court found that a patient, ignoring instructions not to touch a newly applied cast, was contributorily negligent when he attempted to remove a cast with a stolen table knife.[105] Although he was permanently disabled as a result of the injury, the patient was totally barred from recovery.[106] Similarly, in *Musachia v. Rosman*,[107] where a patient left the hospital prior to the physician's advice, and failed to follow dietary instructions, the Florida Supreme Court held that the patient was solely responsible for his own death.[108] The California Court of Appeals agreed with this reasoning in *Gerber v. Day*,[109] where a physician was absolved of liability for failing to give a tetanus anti-toxin since the patient neglected to fill a prescription for the medication.[110]

Conversely, courts have also found that a patient's failure to follow a physician's instructions did not constitute contributory negligence. In *Krauss v. Ballinger*,[111] the court held that where a physician is negligent, a physician is liable, even if the patient did not carry out his instructions.[112] Similarly, in *Heller v. Medine*,[113] the court held that a patient's failure to follow post-operative instructions after cataract surgery (which resulted in the loss of her vision) did not constitute contributory negligence sufficient to bar recovery. Her actions did, however, serve to mitigate her claim for damages.[114]

A second area where courts were willing to find contributory negligence is where the patient failed to return for recommended treatment.

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101. *See infra* notes 104-14 and accompanying text.
102. *See infra* notes 115-22 and accompanying text.
103. *See infra* notes 123-40 and accompanying text.
104. 69 S.W.2d 697 (Ky. 1934).
105. *Id.* at 706.
106. *Id.*
107. 190 So. 2d 47 (Fla. 1966).
108. *Id.* at 50.
109. 6 P.2d 535 (Cal. Dist. Ct. App. 1931).
110. *Id.* at 536.
111. 171 Ill. App. 534 (1912).
112. *Id.*
113. 377 N.Y.S.2d 100, 102 (1975).
114. *Id.*

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In *Jones v. Angell*,[115] the Indiana Supreme Court found that a patient was contributorily negligent for failing to return for treatment and noted that "if he aggravates the case by his misconduct, he can not [sic] charge to the physician the consequences due distinctly to himself."[116] In *Mecham v. McLeay*,[117] a physician failed to diagnose a patient's pernicious anemia.[118] Following that failure, the patient refused to follow the physician's instructions to return for further testing. The Nebraska Supreme Court held that the patient was contributorily negligent.[119]

Even where the patient fails to return for recommended treatment, some courts have avoided the application of a contributory negligence defense. In *Goettl v. Edelstein*,[120] a patient was discharged from the emergency room and died twelve hours later. The physician could not claim contributory negligence for the patient's failure to return because, as the family testified, the patient believed she understood and followed the physician's instructions.[121] The Ohio Court of Appeals noted that the burden is on the physician to clearly communicate instructions and determine that the patient sufficiently understands them.[122]

A third situation where courts, adhering to the traditional view of the physician-patient relationship, have found sufficient proximate cause to hold a patient contributorily negligent is the failure to inform the physician of a pre-existing condition.[123] The courts, however, are more likely to find contributory negligence inappropriate in this situation. The courts, in deciding the issue of contributory negligence when the patient failed to inform the physician of a pre-existing condition, consider whether the plaintiff knew of the importance of the omitted information.[124] In these cases, courts have focused on the disparity in the level of knowledge between the patient and physician.[125]

In *Favalora v. Aetna Casualty & Surety Co.*,[126] the Louisiana Court of Appeals held that a patient had no duty to voluntarily repeat

115. 95 Ind. 376 (1884).

116. *Id.* at 381.

117. 227 N.W.2d 829 (Neb. 1975).

118. *Id.* at 830-31.

119. *Mecham*, 227 N.W.2d at 834.

120. No. CA-2218 (Ohio Ct. App. June 26, 1984) (LEXIS, States library, Ohio file).

121. *Id.* at *4.

122. *Id.* The court also held that for contributory negligence to constitute a defense, the patient's conduct "must be concurrent, direct and proximate." *Id.* at *5.

123. *See, e.g.*, Reynolds v. Smith, 127 N.W. 192 (Iowa 1910) (contributory negligence was a question for the jury when patient failed to disclose her symptoms).

124. Mackey v. Greenview Hosp., Inc., 587 S.W.2d 249 (Ky. Ct. App. 1979).

125. *See infra* text accompanying notes 126-40.

126. 144 So. 2d 544 (La. Ct. App. 1962).

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her medical history to each person who treated her.[127] The physician failed to secure a medical history from the patient prior to his examining her.[128] The plaintiff was referred to the defendant by her regular physician for examination and treatment of stomach pain and fainting spells.[129] While under the defendant's treatment, the plaintiff fainted and fell, sustaining the injury.[130] The court held that the patient had no affirmative duty to volunteer information relevant to her treatment.[131] Because the patient lacked specialized training, she could not be expected to select and communicate to her physicians those aspects of her medical history which were pertinent to her treatment.[132] The court found that the physician was in a far better position to elicit this information from the patient before commencing his treatment.[133]

Similarly, in a wrongful death action resulting from alleged malpractice, the New York Court of Claims, in *O'Neil v. State*,[134] held that a patient who neglected to inform a physician that she was a drug addict was not contributorily negligent.[135] The physician was not relieved of liability for her death, which resulted from his failure to adequately treat her addiction, even though the patient's negligence was contemporaneous with his.[136] The plaintiff had been voluntarily admitted to a hospital for treatment of an acute barbiturate overdose.[137] The plaintiff informed the physician that she had taken the barbiturates, but failed to state that she was an addict.[138] The court found that although the patient had neglected to inform the defendant of a factor crucial for obtaining appropriate treatment, the defendant was negligent for failing to obtain an adequate medical history.[139] The court determined that the patient relied upon the superior resources available to the physician in ascertaining pertinent information.[140]

In discerning the proximate cause of a patient's injury to support a defense of contributory negligence, courts traditionally imposed a heavy burden on the physician to show that the plaintiff was sufficiently

127. *Id.* at 550.
128. *Id.* at 549.
129. *Id.* at 546-47.
130. *Id.* at 547.
131. *Id.* at 550.
132. *Id.*
133. *Id.*
134. 323 N.Y.S.2d 56 (1971).
135. *Id.* at 61.
136. *Id.* at 61-62. See *supra* notes 87-100 and accompanying text for a discussion of concurrency as related to a medical malpractice action.
137. *O'Neil*, 323 N.Y.S.2d at 62.
138. *Id.* at 61.
139. *Id.* at 62-63.
140. *Id.*

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aware of his condition.[141] Even where the negligence of the parties was clearly contemporaneous, some courts persisted in denying the defense. In *O'Neil*, for example, where the patient may have willfully withheld relevant information from the physician and the negligence of each party was clearly simultaneous, the negligence of the patient did not constitute contributory negligence.[142] The burden of proving contributory negligence was rarely met in courts adhering to the traditional model of the physician-patient relationship.

D. Summary of the Traditional Model of the Physician-Patient Relationship

Application of tort concepts to a medical malpractice action requires consideration of the unique relationship between a physician and a patient. Factors unique to this relationship include the imprecise nature of the science of medicine, the level of education and knowledge required to practice medicine, the presumed inexperience of the patient, the emotional nature of the injury, and the level of trust the patient is presumed to place in the physician's judgment. The physician is assigned a high degree of responsibility for a patient's health, and this responsibility becomes a heavy burden for a physician in a malpractice action.

Generally, in assessing the defense of contributory negligence in a medical malpractice action, the facts must be carefully evaluated to determine the real and proximate cause of the plaintiff's injuries. Further, it must be shown that the plaintiff has met the elements required for contributory negligence as determined by the state's statutes or common law. The possibility that the plaintiff assumed the risk of injury should also be evaluated. The defendant must also show that her actions were not culpable under the particularly susceptible victim or the last clear chance doctrines.

In assessing contributory negligence under the traditional model of the physician-patient relationship, since contributory negligence required that the plaintiff's negligent actions be concurrent with those of the defendant, it had to be shown that the plaintiff's conduct was neither pre-existing nor a failure to avoid the consequences. These burdens were rarely met.

141. *See supra* text accompanying notes 126-40.

142. *O'Neil*, 123 N.Y.S.2d at 62-63.

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III. A Contemporary Assessment of Contributory Negligence in a Medical Malpractice Action

A. *The Contemporary Model of the Physician-Patient Relationship*

In the past two decades, there has been increasing discussion of the "health care crisis" in the United States.[143] The following factors contribute to this "crisis":

> rising costs; financial and other barriers to care; geographic maldistribution of manpower and facilities; overspecialization of providers; overutilization of hospitals; deficiencies in quality and control; a tendency, particularly among physicians, to stress the unusual at the expense of the commonplace; barriers to provider-patient communication; training and educational programs and research undertakings that are not always directly relevant to patient needs; an emphasis on treatment rather than prevention; and an orientation toward patients with acute, physical problems at the expense of patients who are chronically ill or have mental problems.[144]

Since health is such a vital component in societal well-being, a malfunctioning health care delivery system can easily be perceived as a social crisis. "Where social problems exist there are usually social movements to combat them. In the case of health care, there is a significant consumer movement."[145]

The increase in health care consumerism implies that individuals are more involved and aware of health care issues.[146] The growth of health care consumerism can be attributed to rising medical costs and the growing number of alternatives available to patients. Rising costs and expanding choices increase patients' expectations of both the health care system and the individual provider.[147] These expectations,

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143. STEVEN JONAS, HEALTH CARE DELIVERY IN THE UNITED STATES 1-5 (1981).

144. *Id.* at 5.

145. PATRICIA A. HAMILTON, HEALTH CARE CONSUMERISM 148 (1982). One consumer advocate group is the Health Research Group, which has "researched and publicized the interests of consumers in nutrition, unnecessary surgeries, occupational health, costs of health care, and many other issues. This organization has offered testimony before numerous congressional committees and has served as a technical resource on matters of health care from the consumer perspective." *Id.* at 153-54.

146. In 1970, the National Welfare Rights Organization drafted the first comprehensive statement of patients' rights, which compiled consumer demands and expectations of the health care system. Annas, *supra* note 10, at 1202. In 1972, The American Hospital Association (AHA) drafted a Patient's Bill of Rights, "[b]ased on the premise that '[the] traditional physician-patient relationship takes on a new dimension when care is rendered within an [institutional] structure.'" *Id.* at 1203. In 1973, the U.S. Department of Health, Education, and Welfare recommended that "'hospitals and other health care facilities adopt and distribute statements of patients' rights in a manner which most effectively communicates these rights to all incoming patients.'" *Id.* (citation omitted).

147. *Id.* at 1201-02; *see also* ZAREMSKI & GOLDSTEIN, *supra* note 58, § 1:02.

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coupled with increased patient awareness, diminish the perceived disparity in medical knowledge between the concerned patient and the physician. The traditional physician-patient relationship was based on trust, but "with the growth of knowledge and technology and higher levels of education among the public, many physicians have difficulty in maintaining credible claims to special status and judgment."[148] The authority of the physician is eroded by increasing health care consumerism.[149]

"[T]he modern patient has been able to increase his role in determining the nature of his care because of widespread and increasing knowledge among laymen about science and recent medical advances. In this sense, the patient becomes an intellectual partner in his own care."[150] As the patient's knowledge of technical issues grows, so does his awareness of legal alternatives for perceived variations. This trend contributes to the rise in medical malpractice litigation.[151]

B. A Medical Malpractice Claim Based on the Contemporary Model of the Physician-Patient Relationship

While courts traditionally required physicians to meet rigid standards in proving the elements of concurrency and proximate cause to maintain a defense of contributory negligence, recent decisions indicate that these standards may be changing. Although physicians continue to be held to a high standard of knowledge in medical decision-making, health care consumers are now better educated and more aware of the consequences of their behavior than they were in the past.[152] Possibly as a result of this trend, courts have begun to impute to patient-plaintiffs a higher responsibility for their own health care decisions.[153]

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148. David Mechanic, *Therapeutic Relationship: Contemporary Sociological Analysis*, *in* 4 ENCYCLOPEDIA OF BIOETHICS 1668, 1668 (1978).

149. *Id.*

150. Eric J. Cassell, *Therapeutic Relationship: Contemporary Medical Perspective*, *in* 4 ENCYCLOPEDIA OF BIOETHICS 1672, 1674 (1978).

151. Hauck & Louisell, *supra* note 2, at 1024.

152. ZAREMSKI & GOLDSTEIN, *supra* note 58, § 1:02.

153. *See infra* text accompanying notes 154-208. The Maryland Court of Appeals has noted that:

> [W]e may almost take judicial notice from the widespread publicity emanating from the medical community and public health authorities, that breast cancer is a major killer of women, that if detected early it is curable . . . . To adopt the view that it is not negligent for women to ignore breast changes that are obvious to them would defy medical reality and thus be absurd. But, in essence, that is the proposition urged by appellants—that the law should excuse such negligence, however clear and egregious, provided it follows in time some misdiagnosis or delayed or incorrect intervention by a doctor, and notwithstanding that, but for the neglect, there would be a better-than-even chance of obtaining proper treatment and cure. There is simply no rationality to such a view.

Chudson v. Ratra, 548 A.2d 172, 183 (Md. Ct. Spec. App.), *cert. denied*, 552 A.2d 894 (Md.

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Courts now recognize patients' responsibility for their own health care needs. Only the patient can experience his own physical sensations and only the patient can convey this experience to the physician.[154] The recent movement toward viewing informed consent as a patient's right supports the patient's active participation in the physician-patient relationship.[155] The right to participate assumes the duty to cooperate with diagnosis and treatment to the best of the patient's ability.[156] Patients' "duty to provide information parallels physicians' duty to provide informed consent . . . . Similarly, patients' duty to cooperate parallels the composite duty of physicians to provide diagnosis and treatment . . . ."[157]

Most notably, the traditional requirement for concurrency in time between the negligence of the physician and the patient is merging with the concept of proximate cause. The result is a more rational assessment of causation. Recent decisions note that a patient's actions may take effect either prior to or subsequent to those of the physician and still be a sufficient contributing cause of the patient's injury.

In 1985, in *Reikes v. Martin*,[158] the Mississippi Supreme Court relied on the obviousness of the patient's symptoms in holding that it was reversible error for the judge to remove the question of contributory negligence from the jury's consideration, even though the patient's negligence occurred subsequent to that of the physician.[159] Similarly, in

1988). The plaintiff was found to be contributorily negligent based on delay in seeking further medical treatment after she became aware that the size of a lump in her breast had increased. *Id.* The plaintiff conceded that the delay in seeking medical treatment constituted negligence. She argued, however, that negligence cannot operate to bar recovery since there was legally insufficient evidence that the delay contributed to the spread of the cancer to the point of incurability and lethality. In any event, the plaintiff claimed, her negligence was not concurrent with the physician's primary negligence. The plaintiff further argued that if the physician had acted properly, the cancer could have been treated before it became lethal, i.e. "loss of chance." *Id.* at 176. To establish contributory negligence, the physician met his burden by showing that the plaintiff's negligence occurred at a time when there was still a statistical probability of cure. *Id.* at 177-80.

154. Fall v. White, 449 N.E.2d 628, 633-34 (Ind. Ct. App. 1983).

155. Informed consent requires that all risks of treatment or lack of treatment are explained to the patient before that patient's consent to treatment can be considered effective. If treatment results in harm to the patient, and such harm was not described to the patient prior to his giving consent for the treatment, the patient is not held liable for any injury that results from that treatment. HOLDER, *supra* note 51, at 310. "While disclosure of information [reduces] patients' ignorance, it [also diminishes] the doctors' power within the physician-patient relationship." Jay Katz, *Informed Consent in Therapeutic Relationship: Law and Ethics, in* 2 ENCYCLOPEDIA OF BIOETHICS 770, 777 (1978).

156. Newell v. Corres, 466 N.E.2d 1085, 1090 (Ill. App. Ct. 1984).

157. Beahrs, *supra* note 22, at 190-91.

158. 471 So. 2d 385 (Miss. 1985).

159. The patient failed to return for a two week follow-up visit, remained in bed too long, and did not promptly advise physicians of the formation of blisters and ulcers until the ulcers reached a severe state and emitted a foul odor. *Id.* at 389.

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1988, in *Chudson v. Ratra*,[160] the Maryland Court of Appeals found that a patient's awareness of the symptoms of her illness and subsequent failure to seek treatment was the proximate cause of the injury where such failure prevented diagnosis at a time when the illness was curable.[161] The court described the patient's conduct as contributorily negligent.[162]

> [T]o be contributory, the plaintiff's negligence need not always be congruent in time with the defendant's negligence. The test is not simultaneity but whether the plaintiff's dereliction has significantly contributed to the injury for which he or she sues. Where . . . the injury does not occur immediately upon the defendant's negligence but arises later, it is entirely possible for the plaintiff, by his or her own negligent act or omission, to contribute to the actual creation of the injury.[163]

Grippe v. Momtazee[164] involved a wrongful death action[165] where a physician failed to diagnose a breast mass as malignant.[166] The plaintiff had read articles about breast masses and was aware of the consequences of failure to receive treatment.[167] Although the plaintiff was instructed to examine her breast and return in six months, she failed to return for nineteen months.[168] Furthermore, she refused to see a surgeon when instructed to do so by the physician.[169] Cancer was diagnosed when the plaintiff returned to the same physician seven months later.[170] Discussing the physician's defense of contributory negligence, the Missouri Court of Appeals held that:

> Assuming, arguendo, that there was evidence of negligence on the part of the doctor on the first visit in failing to discover and diagnose the carcinoma, [plaintiff's] failure to return as instructed, rather than aggravating her damages, contributed to the very gist of plaintiff's cause of action: the failure to diagnose the cancer prior to metastasis.[171]

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160. 548 A.2d 172 (Md. Ct. Spec. App.), *cert. denied*, 552 A.2d 894 (Md. 1988).
161. *Id.* at 182.
162. *Id.* at 183.
163. *Id.* at 182-83.
164. 705 S.W.2d 551 (Mo. Ct. App. 1986).
165. Wrongful death is a statutorily created action. KEETON et al., *supra* note 3, § 127. The statutes provide that a claim can be asserted for any wrongful act resulting in the death of another. *Id.* The action is brought for the benefit of the decedent's survivors who have suffered loss as the result of that death. *Id.*
166. *Grippe*, 705 S.W.2d at 555.
167. *Id.* at 553.
168. *Id.*
169. *Id.*
170. *Id.*
171. *Id.* at 555 (footnote omitted). The court approved a jury instruction which had directed the jury to find for the defendants if they believed that the patient's negligence directly caused or directly contributed to cause any damage she may have sustained. *Id.* at 556; *see also*

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The plaintiff's failure to return subsequent to the physician's negligence was found to be both contributory negligence and the proximate cause of the plaintiff's injury.[172]

In 1988, an Ohio trial court in *Sorina v. Armstrong,*[173] found that contributory negligence barred a plaintiff's recovery because the patient, suffering symptoms of an improperly performed abortion, failed to follow up with her physician.[174] The Ohio Court of Appeals found that the physician's negligence was not the actual and proximate cause of the injury.[175] The failure to seek treatment was an intervening cause which broke the causal connection.[176] "[A]ppellant's own disregard for her health proximately caused her injury."[177] The court reached this conclusion even though the parties' negligence did not occur simultaneously.

In 1988, the Kansas Supreme Court also rejected the requirement of concurrency in *Wisker v. Hart.*[178] *Wisker* involved a wrongful death action which arose from medical malpractice. Subsequent to the physician's negligence, the decedent failed to notify the physician of symptoms he experienced after engaging in physical activity which the physician had advised against.[179] The court considered, as a critical factor, the time lost because of the decedent's failure to notify the physician of his condition.[180] The court found that the decedent's failure to inform his physician was the proximate cause of his own injury, thereby justifying the defense of contributory negligence.[181]

Similarly, in *Mackey v. Greenview Hospital, Inc.,*[182] a Kentucky Appellate Court found that the defendant doctors and hospital were not liable for malpractice since the plaintiff failed to inform her surgeon that she was taking a certain medication.[183] During the course of

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Jamas v. Krpan, 568 P.2d 1114 (Ariz. Ct. App. 1977). In *Jamas*, an action for medical malpractice, the court found that an instruction on contributory negligence was justified by defense testimony. *Jamas*, 568 P.2d at 1115-16. The plaintiff "had been told to return to have her breasts re-examined, [she] was knowledgeable about the significance of breast lumps and [she] failed to reveal her history of breast lumps to physicians performing subsequent examinations." *Id.*

172. *Grippe*, 705 S.W.2d at 555.

173. 554 N.E.2d 943 (Ohio Ct. App. 1988), *rev'd on other grounds*, No. L-89-377, 1990 Ohio App. LEXIS 4534 (Ohio Ct. App. October 19, 1990), *jur. motion overruled*, 569 N.E.2d 512 (Ohio 1991).

174. *Id.* at 945.

175. *Id.*

176. *Id.*

177. *Id.*

178. 766 P.2d 168 (Kan. 1988).

179. *Id.* at 171.

180. *Id.* at 172.

181. *Id.* at 174.

182. 587 S.W.2d 249 (Ky. Ct. App. 1979).

183. *Id.* at 257. The patient had been taking the medication Lasix. *Id.* at 252. "Lasix is a potent diuretic which can deplete the body's store of potassium. A low level of potassium increases

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surgery, the plaintiff suffered a cardiac arrest causing severe brain damage due to a lack of oxygenation.[184] The evidence indicated that several doctors failed to ask the patient whether she was taking medication. Further, the patient did not volunteer the information.[185] The court held that although the primary responsibility for obtaining a complete and accurate medical history from the patient is upon the physician, the patient has a duty to use ordinary care for her own safety.[186] The court recognized that a patient's failure to communicate some particular aspect of her medical history would not ordinarily constitute contributory negligence.[187] When, however, a patient is aware that a treating physician failed to ascertain some aspect of her medical history which she knew could involve a risk of harm to herself, ordinary care dictates that she volunteer this information.[188] Since the plaintiff failed to reveal this information, she was held to be the proximate cause of her injury and was therefore contributorily negligent.[189]

In *Schliesman v. Fisher*,[190] the plaintiff claimed medical malpractice against a physician whose conduct allegedly fell below the acceptable standard of care when he discontinued the patient's diabetic medication.[191] The California Court of Appeals found that there was substantial evidence from which a jury could have found that the patient was himself contributorily negligent in failing to follow his doctor's orders regarding diet, weight reduction, and medications.[192] The court determined that such negligence could have proximately contributed to his below-the-knee amputation.[193]

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the risk of cardiac arrest during anesthesia. In the event of cardiac arrest, a low potassium level can interfere with the restoration of normal heart function." *Id.*

184. *Id.*

185. *Id.* at 253.

186. *Id.* at 255. *But see* O'Neil v. State, 323 N.Y.S.2d 56 (1971) (holding patient not contributorily negligent for witholding information).

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

188. *Id.*

189. *Id.* at 257. The patient was charged with this knowledge since she had taken the medication over a long period of time, and was aware that specific drugs had been used to control prior episodes of heart problems. *Id.* at 256.

190. 158 Cal. Rptr. 527 (Cal. Ct. App. 1979) (the opinion was withdrawn by order of the court).

191. *Id.* at 532.

192. *Id.*

193. *Id.* The patient failed "to follow medical advice regarding adherence to his diabetic diet and the need for his discontinuance of beer drinking, together with his tendency to periodically stop taking his medication." *Id.* at 529; *see also* Faile v. Bycura, 374 S.E.2d 687 (S.C. Ct. App. 1988) (finding contributory negligence where a patient failed to follow a physician's orders to wear a post-operative orthotic device).

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Courts appear more willing to allow the defense of assumption of the risk based on the patient's knowledge regardless of the issues of informed consent. In 1991, the South Carolina Court of Appeals, in *Baxley v. Rosenblum*,[194] allowed the jury to find contributory negligence and assumption of risk where the plaintiff was also a physician.[195] The evidence indicated that the plaintiff was aware that a person with his symptoms was at risk of cancer and that "a patient takes a serious . . . risk when he withholds information about his symptoms and their progression."[196] The court noted that the plaintiff made a voluntary decision to take the risk.[197]

Similarly, in 1986, the Supreme Court of South Carolina rejected last clear chance as a cause of action in *Johnston v. Ward*[198]—a wrongful death action arising from claimed medical malpractice.[199] In *Johnston*, the patient withheld information about the specific medications she purposely ingested in excessive amounts.[200] The omission resulted in her death.[201] By refusing to inform the physician of the types of ingested medications, "[h]er negligent conduct continued until the defendants had no last clear chance to save her . . . . [Her conduct] admits to only one conclusion: it contributed directly to her own death."[202]

A plaintiff's claim of last clear chance was also rejected in *Rochester v. Katalan*[203] where the decedent deceived the physician as to the decedent's medical history and symptoms, thereby inducing the physician to prescribe large doses of methadone.[204] The Delaware Supreme Court found that the physician did not have "the last chance to avoid the ultimate consequences . . . . Rather, it was the decedent who put on an effective act which induced the doctor to do what the decedent wanted . . . ."[205] The court found that:

194. 400 S.E.2d 502 (S.C. Ct. App. 1991).

195. *Id.* at 507.

196. *Id.*

197. *Id.* The court also found that the plaintiff's removal of his own post-operative nasogastric tube against his surgeon's orders constituted contributory negligence and assumption of risk. *Id.* Similarly, in 1987, the Georgia Court of Appeals held in *Haynes v. Hoffman* that a patient may be held to assume the risk of failure to take reasonable care of himself. 296 S.E.2d 216 (Ga. Ct. App. 1987). A patient of sound mind who failed to disclose what he knew to be material medical history assumed the risk of his injury. *Id.* at 218.

198. 344 S.E.2d 166 (S.C. 1986).

199. *Id.* at 173.

200. *Id.* at 168.

201. *Id.* at 169.

202. *Id.* at 173 (citation omitted). The court found it unnecessary to address the defendant's allegations of assumption of risk, since the plaintiff was found to be contributorily negligent. *Id.*

203. 320 A.2d 704 (Del. 1974).

204. *Id.*

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205. *Id.* at 708.

> [T]he common-sense duty of a patient [is] to be truthful in describing his symptoms to a physician to whom he looks for assistance. It is the duty of a patient to use such care as a man of ordinary prudence would ordinarily use in circumstances like his own, and if he fails to do this he cannot hold the physician accountable for the consequences of his own want of ordinary care. Wilful or intentional deception of the physician certainly violates that rule.[206]

Where a court, adhering to the traditional model of the physician-patient relationship, would have found the physician responsible for ascertaining the patient's true medical condition prior to initiating treatment,[207] the Delaware Supreme Court held a patient responsible for the consequences of his actions.

C. Summary of the Contemporary Model of the Physician-Patient Relationship

Recent cases illustrate that the rigid standards which courts traditionally required physicians to meet in proving the elements of concurrency and proximate cause for the defense of contributory negligence in a medical malpractice action have relaxed. While no court specifically addressed the changing climate of health care consumerism, it appears that society's increased awareness of health care issues affected judicial decision-making. "The most likely consequence of enforcing patients' duties will be to improve the overall quality of care . . . . Collaboration and informed trust are reinforced in both parties . . . . [P]atients are held to a higher standard of communication and cooperation, and professionals are faced with an informed and active participant."[208] In the midst of a health care crisis, improving the overall quality of care by enforcing patients' responsibilities for their own health care, when appropriate, is a laudable goal.

IV. CONCLUSION

Traditionally, the physician-defendant had a heavy burden of proving contributory negligence in a medical malpractice action. To bar a plaintiff's recovery, the physician was required to prove that the

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206. *Id.* at 709 (citation omitted).

> [The decedent] causally contributed to his death up to the time when it occurred. Had he informed defendants or hospital personnel that he neither was currently nor had ever been a heroin addict (even after the original deliberately misleading statements and actions), proper measures might have been taken to avoid potential ill effects from administration of the methadone. It is the failure to exercise the power to correct the situation which rendered decedent's actions continuing negligence on his part.

Id. at 708.

207. *See supra* text accompanying note 96.

208. Beahrs, *supra* note 22, at 193-94.

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plaintiff's negligence was the real and proximate cause of the injury and occurred concurrently with the physician's negligence. The requirement that a patient exercise the degree of care expected of a reasonable person under similar circumstances was profoundly affected by disease, pain, disability, and medication. The relationship of trust between the physician and patient, and the great disparity presumed between the knowledge of each, however, resulted in a nearly impossible burden for the physician-defendant in proving that the patient was aware of the importance of his condition and treatment. Ultimately, the patient's conduct had to be significantly unreasonable to bar recovery.

Recent judicial trends indicate a change in the standards applied to contributory negligence claims. The health care crisis of recent years resulted in increased consumer activism and awareness of health care issues. Courts appear to be cognizant of this increasing consumer awareness and as a result are willing to hold a patient to a higher degree of responsibility for his own health care decisions. Thus, a patient's refusal to exercise due care to protect his own health needs is more likely to be found the proximate cause of a resultant harm. Accordingly, an injured patient can no longer rely on the requirement that his own negligence occurred concurrently with the physician's negligence.

It appears that as health care consumers become more aware and involved in health care issues, there will be a corresponding increase in the degree of responsibility a patient will be required to assume in his own health care decisions. Because the disparity between the patient's and the physician's knowledge is diminishing, absolute trust in the physician's judgment is no longer justified in all cases. In a society concerned with health care issues, courts may increasingly demand individual responsibility for health care decisions. As noted by the Maryland Court of Appeals, "[t]o adopt the view that it is not negligent for [patients to ignore symptoms] that are obvious to them would defy medical reality and thus be absurd."[209]

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209. Chudson v. Ratra, 548 A.2d 172, 183 (Md. Ct. Spec. App.), *cert. denied*, 552 A.2d 894 (Md. 1988).

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