1963

Contibutory Negligence in Medical Malpractice

W. David Alderson

Contributory Negligence in Medical Malpractice

*W. David Alderson**

THREE CATEGORIES OF CASES have been noted[1] out of the mass of factually individualistic ones concerning medical malpractice and contributory negligence. The first, where a breach of duty owed the patient by the physician is lacking, involves an injury produced by the patient's own negligence. In the second, the patient's negligence directly contributes to the severity of an injury already present because of the physician's negligence. The plaintiff-patient's damages are not mitigated but rather entirely precluded in light of his acts.[2] Thus a plea of contributory negligence is a complete defense. The third category includes those cases where a time lag exists between the separate negligent acts, each of which produces significant injury. The physician is chargeable only with the consequences of his own negligence, not subsequent acts of his patient.[3]

Recognizing these generalized differences, it would be beneficial to an understanding of this field of tort law to review the nature of contributory negligence and its application to medical malpractice litgation. Cases will follow to crystallize some of this fundamental law.

Contributory negligence is

> . . . an act or omission on the part of the plaintiff, constituting a failure to exercise the care which ordinarily prudent persons are accustomed to employ for their own safety which, concurring or co-operating with the negligent acts of the defendant, is a proximate cause of the injury of which the plaintiff complains.[4]

In many cases, it is a complete defense.[5] As far as the law is con-

---

* B.S., Univ. of Idaho; M.B.A., Univ. of Wisconsin; Third-year student at Cleveland-Marshall Law School.

1 Annot., 17 L. R. A. (n. s.) 1242 (1909).

2 *Id.*, at 1243.

3 *Ibid.*

4 Champs v. Stone, 74 Ohio App. 344, 58 N. E. 2d 803 (1944).

5 Prosser, Law of Torts 284 (2d ed., 1955). There is a split of authority here. (1) Any negligence on the part of the plaintiff which is a con-

(Continued on next page)

cerned the parties should be left in the relative positions in which they were found.

When applied to cases of medical malpractice, the reasonable-prudent standard for acts of commission or omission amounting to contributory negligence is slightly changed.[6]

> . . . the patient is required to exercise for his own welfare that degree of care and prudence which would be used by an ordinary, careful and prudent patient in the same circumstances.[7]

Care and prudence, actually influenced by the awareness of certain facts, are imprecise concepts when viewed in the unequal relation of patient-physician. The factual circumstances of each new case make precedent usually inapplicable; the formation of definitive law nearly impossible.

This type of litigation is unique in the amount of critical concern which must be focused upon the usually long time period between the initial injury and the subsequent acts of the parties. The physician's ministrations and the day-to-day fluctuations in his patient's condition must be scrutinized. The long period of treatment requires that the doctor's actions be evaluated in view of his overall performance. The patient's negligence, which may be cumulative in causation, must also be evaluated. The patient is often inactive during the time of treatment; contributory negligence cannot be established.[8] It could be established, however, by looking for a failure of cooperation or failure to submit to treatment and reliance upon the physician. Procedurally, each distinctly different factual situation must be carefully molded to the law; a law which is, at least, somewhat confused.[9]

(Continued from preceding page)

tributing cause of the second injury will defeat recovery: Stahl v. Southern Michigan Ry., 211 Mich. 350, 178 N. W. 710 (1920); Koonse v. Standard Steel Works Co., 221 Mo. App. 1231, 300 S. W. 531 (1927). (2) Recovery from the defendant will be allowed unless the plaintiff's negligence amounts to an intervening cause and proximately contributes to the second injury: S. S. Kresge Co. v. Kenney, 86 F. 2d 651 (D. C. Cir. 1936); Yarbrough v. Polar Ice & Fuel Co., 118 Ind. App. 321, 79 N. E. 2d 422 (1948).

[6] Flynn v. Stearns, 52 N. J. Super. 115, 145 A. 2d 33 (1958); Halverson v. Zimmerman, 60 N. D. 113, 232 N. W. 754 (1930); Wemmett v. Mount, 134 Ore. 305, 292 Pac. 93 (1930).

[7] Carnahan, The Dentist and The Law 55, 61 (1st ed., 1955).

[8] Stetler & Moritz, Doctor and Patient and the Law, 368 (4th ed., 1962; Shartel & Plant, The Law of Medical Practice 153 (1st ed., 1959).

[9] Annot., 17 L. R. A. (n. s.) 1242 (1909).

Proximate Cause

The problematical issue of causation is most easily discussed through case illustration. To establish a valid defense, the patient's negligence must be the proximate cause of the injury.[10]

In *Stacy v. Williams*,[11] the patient was treated for a broken leg over a period of eighty-three days. The bones were placed in apposition, splinted, and suspended by pulley and weights. In this position the fracture should have healed. However, the patient removed the splint from his leg, allowing it to lie flat upon the bed. Repeated cautioning by the physician against such action was ineffective. The patient simply procured others to lower his leg, thereby permitting a desired shift in his body position. It was soon apparent that the leg was not and would not heal. Thereupon, an open reduction operation was performed in which the bones were placed in apposition and secured in place by screws and a metal plate. In addition, a plaster cast was used to keep the leg immobile. In spite of this, Williams twisted and turned the cast with his hands, swung the leg from side to side with the aid of his other leg, whittled away the cast with a knife taken from one of his meal trays, and opened and closed the bandages over the incision. Consequently, an infection set in which caused improper knitting of the bones. The doctor resorted to a second cast, one which extended around the patient's body. Undeterred, Williams continued to be uncooperative, causing his subsequent removal to another hospital. At the trial level, the patient was awarded $5,500 in damages. In reversing this decision, the Appellate Court stated that a person whose acts amount to moral delinquency is deemed to be in *pari delicto* with the negligent physician and, therefore, will be denied recovery upon the principle of contributory negligence.

In a similar factual situation the patient in *Leonardo v. Sloan*[12] left the hospital for two days without permission, did not follow a prescribed diet, and removed the dressing from his skin graft. Proximate cause could not be established where the evidence proved that none of his acts had any effect upon his recovery or upon the prior negligence of the physician. Recovery was allowed.

---

10 Halverson v. Zimmerman, *supra* n. 6; *Wemmett v. Mount, supra* n. 6; see generally 70 C. J. S. 973.

11 253 Ky. 353, 69 S. W. 2d 697 (1934).

12 23 D. & C. 2d 201 (1959).

An important facet of proximate cause involves the proximity of the patient's acts to those of the physician. The former must occur simultaneously and in cooperation with the latter.[13] They must be the direct, active, producing, and efficient cause.[14] Where the patient's negligence follows, by any significant time, that of the physician, the case is one of subsequent or supervening negligence. This results, in practical effect, in mitigation of the award, not necessarily an elimination of it.[15] For example, where a minor received negligent treatment for a broken arm, her subsequent failure to exercise the arm as directed was an omission which aggravated the previous injury. Her recoverable damages were reduced accordingly.[16]

Patient's Duty to Follow Instructions

Failure to follow the reasonable instructions prescribed by a physician has been held to be contributory negligence.[17] This is a general rule which imposes a duty upon the patient.[18] In a case[19] on point, the doctor had placed a cast on a child's broken arm in such a manner that the blood flow through the arm was severely constricted. When the arm began to swell, the defendant requested that his patient remain in the hospital. The patient's father refused to comply with the request and as a consequence, the arm became infected and began to deteriorate. The physician's

---

[13] Halverson v. Zimmerman, *supra* n. 6; Leadingham v. Hillman, 224 Ky. 177, 5 S. W. 2d 1044 (1928).

[14] Breece v. Ragan, 234 Mo. App. 1093, 138 S. W. 2d 758 (1940); Sanderson v. Holland, 39 Mo. App. 233 (1889); Hibbard v. Thompson, 109 Mass. 286 (1872).

[15] Flynn v. Stearns, *supra* n. 6; Maertins v. Kaiser Foundation Hospital, 162 Cal. App. 2d 661, 328 P. 2d 494 (1958); Josselyn v. Dearborn, 143 Me. 328, 62 A. 2d 174 (1948); Leadingham v. Hillman, *supra* n. 13; Schultz v. Tasche, 166 Wis. 561, 165 N. W. 292 (1917); Sauers v. Smits, 49 Wash. 557, 95 P. 1097 (1908); McCracken v. Smathers, 122 N. C. 799, 29 S. E. 354 (1898); DuBois v. Decker, 130 N. Y. 325, 29 N. E. 313 (1891); Sanderson v. Holland, *supra* n. 15; Wilmot v. Howard, 39 Vt. 447, 94 Am. Dec. 338 (1867).

[16] Flynn v. Stearns, *supra* n. 6.

[17] Brown v. Dark, 196 Ark. 724, 119 S. W. 2d 529 (1938).

[18] Josselyn v. Dearborn, *supra* n. 15; Lucas v. Hambrecht, 1 Ill. App. 2d 226, 117 N. E. 2d 306 (1954); Donathan v. McConnell, 121 Mont. 230, 193 P. 2d 819 (1948); Chapman v. Loer, 193 Wash. 569, 76 P. 2d 600 (1938); McDonnell v. Monteith, 59 N. D. 750, 231 N. W. 854 (1930); Chubb v. Holmes, 111 Conn. 482, 150 A. 516 (1930); McClees v. Cohen, 158 Md. 60, 148 A. 124 (1930); Feltman v. Dunn, 52 S. D. 187, 217 N. W. 198 (1927); Gentile v. DeVirgilis, 290 Pa. 50, 138 A. 540 (1927); Hanson v. Thelan, 42 N. D. 617, 173 N. W. 457 (1919); Dunman v. Raney, 118 Ark. 337, 176 S. W. 339 (1915); Merrill v. Odiorne, 113 Me. 424, 94 A. 753 (1915).

[19] Brown v. Dark, *supra* n. 17.

liability for the injury was absolved by the father's failure to follow the reasonable instructions.

Cases involving reasonable, ordinary, and usual treatments adhere to the same duty principle.[20] A duty to submit to treatment is fixed even though the patient may be ignorant of the consequences of a refusal.[21] Should a particular treatment be refused, the doctor may care for his patient in all other particulars without incurring liability for malpractice in the course pursued.[22]

Littlejohn v. Arbogast[23] concerned such a duty. The patient had a broken back and dislocated hip, but neither he nor those in charge of him would allow the doctor to apply the proper treatment. Contributory negligence formed the basis for disallowing the claim. The Court reasoned that, with the existence of a duty to submit to necessary treatment, if the patient was delirious and without faculties to understand the necessity for the treatment, then his immediate family was empowered to consent. However, where both patient and family refuse, the physician is not required to use force in overcoming the opposition; and he is, thereby, absolved of any liability for resulting injury.

In a subsequent decision,[24] the duty to submit was judged by what the patient knew relative to the information she received from her physician. The patient had undergone surgery for varicose veins. Subsequently, she was in constant pain apparently caused by a paravertebral block, for which she repeatedly refused treatment. During the trial, she testified that she had no recollection of declining treatment, but this was overcome by the hospital records listing the date of each refusal. The Court's decision denied contributory negligence by placing a continuing duty upon the physician. Where his patient is incompetent or incapable of understanding the necessity for treat-

---

[20] Josselyn v. Dearborn, *supra* n. 15; *Carey v. Mercer*, 239 Mass. 599, 132 N. E. 353 (1921); Summers v. Tarpley, 208 S. W. 266 (Mo. App. 1919); Peterson v. Branton, 137 Minn. 74, 162 N. W. 895 (1917); Merrill v. Odiorne, *supra* n. 18; McGraw v. Kerr, 23 Colo. App. 163, 128 P. 870 (1912); Haering v. Spicer, 92 Ill. App. 449 (1900). See generally 70 C. J. S. *op. cit. supra* n. 10 at 974.

[21] Carey v. Mercer, ibid.

[22] Shannon v. Ramsey, 288 Mass. 543, 193 N. E. 235 (1934); Routt v. Ready, 265 F. 455 (C. A., D. C. 1920).

[23] 95 Ill. App. 605 (1900).

[24] Steele v. Woods, 327 S. W. 2d 187 (Mo. 1959).

ment he must advise the husband or member of the immediate family, one able to speak for the patient, of the urgent need. Any failure to do so destroys his defense.

Reliance on the Physician

Negligence is not established, *prima facie*, when a patient, unaware of improper treatment, relies on and trusts the professional skill of his physician, thereby not calling in other physicians for advice.[25] In *Los Alamos Medical Center v. Coe*[26] the patient, having been discharged from the hospital, was assured by her physician that she could be given morphine whenever she felt a need for it. Soon after inquiries of the husband and wife were satisfied by the physician, she became a drug addict. No contributory negligence was found when the Court considered reliance upon the physician's advice, even though the patient, in order to obtain the drug, had often complained of pain when none was present.

Although under a duty to follow a recommended treatment, a patient has no duty to reiterate her entire medical history to every person on the hospital staff with whom she comes in contact.[27] Mrs. Favalora was admitted to her physician's hospital to undergo observation for determining the cause of her fainting spells. She was prepared by the administration of opaque chemical compounds for a series of fluoroscopic and x-ray examinations of her chest, gall bladder, and gastro-intestinal tract. While standing before a fluoroscope, she became dizzy, collapsed, and suffered multiple injuries. Contributory negligence was ruled out when the Court stated that she was entitled to rely, not only on the skill of her own physician, but also upon the competence of specialists into whose care she was committed. They had access to her medical records and, therefore, should have known that she was subject to such spells.

A patient may not rely on the professional skill of a physician

---

[25] Kelly v. Carroll, 36 Wash. 2d 482, 291 P. 2d 79 (1950); Halverson v. Zimmerman, *supra* n. 6; *Schoonover v. Holden*, 87 N. W. 737 (Iowa, 1901); DeMay v. Roberts, 46 Mich. 160, 9 N. W. 146 (1881). See generally 70 C. J. S. *op. cit. supra* n. 10 at 975.

There is no *prima facie* negligence where, following the infliction of an injury caused by a negligent physician, he is discharged and another employed: McClees v. Cohen, *supra* n. 18; George v. Shannon, 92 Kan. 801, 142 P. 967 (1914).

[26] 58 N. Mex. 686, 275 P. 2d 175 (1954).

[27] Favalora v. Aetna Casualty & Surety Co., 144 S. 2d 544 (La. App. 1962).

when he is fully aware that the doctor is not treating him properly.[28] In a situation where a patient had undergone two negligent treatments on a fractured arm, he would not be contributorily negligent if he refused to have his arm rebroken for a third time.[29] *Champs v. Stone*[30] presented a patient who was persuaded to submit to a blood test by a physician he knew to be intoxicated. As a result, the doctor's needle penetrated the bone of the forearm, thereby causing a bone infection. Contributory negligence as a matter of law barred recovery. In this situation, ordinary care for one's safety would have caused the careful and prudent person to seriously doubt the physician's capability and therefore refuse treatment.

---

[28] Halverson v. Zimmerman, *supra* n. 6; Hanley v. Spencer, 108 Colo. 184, 115 P. 2d 399 (1941).

[29] Parr v. Young, 121 Kan. 47, 246 P. 181 (1926).

[30] *Supra* n. 4.