

WITH PATIENT RIGHTS COME PATIENT RESPONSIBILITIES: CONTRIBUTORY NEGLIGENCE IN MEDICAL NEGLIGENCE ACTIONS

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1. Introduction

In the latter half of the twentieth century, significant changes to the physician-patient relationship occurred, profoundly changing the roles of both physicians and patients in Canada. The traditional beneficence model of medicine,¹ where treatment and providing medical benefits often surpassed patient autonomy, evolved into a model premised on patient rights. These patient rights are governed by the societal norms for autonomy and are coupled with the respective rights and duties of physicians.²

Several factors have contributed to the decline of the beneficence model of medicine in Canada. From the professionalization of Canadian medicine to the growth of specialization in medical knowledge and technology; from the emergence of the modern hospital to the onset of public health insurance; from the proliferation of paramedical personnel to ever-greater demands from patients for a say in assessing and attending to their medical

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1. In their detailed study, *A History and Theory of Informed Consent*, Ruth Faden and Tom L. Beauchamp define the "beneficence model" as depicting "the physicians' responsibilities of disclosure and consent-seeking as established by the principle of beneficence, in particular through the ideal that the physician's *primary* obligation (surpassing obligations for respect of autonomy) is to provide *medical* benefits" (at p. 59). For a detailed review of this topic, see for example Ruth Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986).
2. *Ibid.*

needs, changes to the health care system and Canadian society have fundamentally altered the relationship between physicians and patients.³

In an earlier era, the physician was something more than a skilled professional; he was regarded as a trusted advisor, a "counsellor", and at times, even a family friend. Physicians were highly regarded and respected, and not mere providers of medical services. Hospitals were few in number, and those that did exist were little more than "asylums for the sick".⁴ The Canadian population was sparse, scattered and diverse. With only a small number of urban centres and few trained physicians, many Canadians relied upon "irregular" practitioners and other unscientific and unorthodox sources for their general health care.⁵ In a legal system where one's status was defined by reciprocal duties and obligations, the beneficence model of medicine was best suited to delineate the boundaries of the relationship between the physician and patient.

During the latter half of the twentieth century, as patient demands for autonomy or at least a greater role in their own health care increased, the courts saw fit to infuse a discourse of rights into the legal principles that define and delineate the physician-patient relationship at law.⁶ Some commentators have hypothesized that this shift in the common law came in response to what many jurists perceived as the historical inequality of the physician-patient relationship, premised on the old adage that "doctor knows best".⁷ Remedial steps were necessary, so the argument goes, to correct this imbalance, creating equilibrium and affording patients the legal foundation to assert autonomy in their own health care and treatment.

3. Bernard R. Blishen, *Doctors in Canada: The Changing World of Medical Practice* (Toronto: University of Toronto Press, 1984), pp. 3-5.

4. Government of Canada, *Report of the Royal Commission on Health Services* (Ottawa: Queen's Printer, 1964), vol. 1, pp. 229-30.

5. *Doctors in Canada*, *supra*, footnote 3, at p. 9. Irregular practitioners included homeopathic healers whose skills were utilized by many Canadians well into the early decades of the twentieth century.

6. The most significant decision in this regard was that of the Supreme Court of Canada in *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1, 14 C.C.L.T. 1. *Reibl* is often cited as a watershed in Canadian medical law. For discussions on this point, see, for example, Sanda Rodgers-Magnet, "Recent Developments in the Doctrine of Informed Consent to Medical Treatment" (1981), 14 C.C.L.T. 61 and Ellen I. Picard, "Patients, Doctors and the Supreme Court of Canada" (1981), 1 Oxford J. Leg. Stud. 441.

7. See, for example, Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Carswell: Toronto, 1996), p. 111.

While this shift in the common law undoubtedly produced lauded results, it also created inconsistencies between the law of general negligence and that of medical negligence. This has been the result of hesitancy on the part of the courts to recognize and enforce the corresponding patient obligations that necessarily accompany greater patient autonomy at law. Indeed, reviewing the jurisprudence, it appears that the courts have historically failed to recognize this dichotomy, choosing instead to advance the discourse of "rights" while simultaneously failing to define the obligations that accompany those rights. A notable historical inconsistency between the general law of negligence and medical negligence is in the area of contributory negligence. While contributory negligence is a well-established defence and receives widespread application in general negligence actions, it is less widely accepted and applied in medical negligence actions.

In their treatise *Legal Liability of Doctors and Hospitals in Canada*,⁸ Picard and Robertson opine that one explanation for the limited use of the defence of contributory negligence in medical negligence actions has been the perceived inequality of the physician-patient relationship, notwithstanding a recognition of the autonomy of patients in other areas of medical law, including, for example, the law of consent to treatment.⁹ This perceived disparity, Picard and Robertson argue, has prompted many courts to set the standard of care that patients must adhere to at an unreasonably low level, thereby effectively precluding the availability of this defence for defendant-physicians.¹⁰

This article will argue that the limited use and application of the defence of contributory negligence in medical negligence actions is inconsistent given the recognized autonomy of patients in other areas of medical law. Accordingly, there is no basis for a continued preclusion of the defence of contributory negligence in medical negligence actions. To this end, this article will propose several duties that patients must adhere to, failing which a finding of contributory negligence with respect to their own care and treatment is appropriate. These duties and principles have been articulated in recent lower court medical negligence decisions that have discussed

8. *Ibid.*, at p. 284.

9. *Reibl*, *supra*, footnote 6. To be sure, there are a few early examples of the application of the defence of contributory negligence in medical negligence actions. See, for example, *Bernier v. Sisters of Service*, [1948] 1 W.W.R. 113 (Alta. S.C.); *Murrin v. Janes*, [1949] 4 D.L.R. 403 (Nfld. T.D.); *Hopital Notre-Dame de l'Esperance v. Laurent*, [1978] 1 S.C.R. 605, 3 C.C.L.T. 109, 17 N.R. 593 *sub nom. Laurent v. Theoret*.

10. *Legal Liability of Doctors and Hospitals*, *supra*, footnote 7, at p. 284.

the defence. While this jurisprudence is still at a formative level, it provides a framework for further development in this area of health law.

2. Overview of the Defence of Contributory Negligence

Prior to examining the defence of contributory negligence in the context of medical negligence actions, it will be useful to review the principle of contributory negligence as it applies to tort actions in general. As Prosser and Keeton note, "contributory negligence is conduct on the part of the plaintiff, contributing as a legal cause to the harm that he has suffered, which falls below the standard to which he is required to conform for his own protection".¹¹ Unlike other defences, such as the assumption of risk, contributory negligence is not premised on the idea that the defendant is in any way relieved of his duty towards the plaintiff. Rather, the defence of contributory negligence denies the plaintiff's recovery on the basis that her own behaviour disentitles her from maintaining the action.¹²

As Picard and Robertson note, while at one time evidence of negligence on the part of a plaintiff constituted a complete bar to recovery, provincial legislation now directs the courts "to apportion damages in proportion to the degree of fault found against the respective parties".¹³ In Ontario, ss. 3 and 4 of the *Negligence Act* provide for the apportionment of damages in cases involving contributory negligence.¹⁴

In order to successfully advance the defence of contributory negligence, a defendant must establish that the negligence is causally related to the plaintiff's loss. In this respect, contributory negligence will be relevant only where the plaintiff and defendant have each contributed materially to the plaintiff's loss through their negligence.¹⁵ Moreover, it is instructive to note that in the context of the defence of contributory negligence, the plaintiff must meet the same standard of care as the defendant, and must, at all times, act reasonably and in her own best interests.

11. W. Page Keeton, ed., *Prosser and Keeton on Torts*, 5th edition, *Handbook Series* (St. Paul Minnesota, West Publishing, 1984), p. 451.

12. *Ibid.*, at pp. 451-52.

13. Picard and Robertson, *supra*, footnote 7, at p. 283.

14. On the issue of costs in cases of contributory negligence, see, for example, *Ferguson v. Henshaw*, [1989] B.C.J. No. 1199 (QL), 16 A.C.W.S. (3d) 162 (S.C.). See the *Negligence Act*, R.S.O. 1990, c. N.1.

15. Rainaldi *et al.*, eds., *Remedies in Tort* (Carswell: Toronto, 2004 release), looseleaf ed., vol. 2, at p. 1611-23.

Accordingly, in the context of medical negligence actions, patients are imbued with certain duties and obligations with respect to their own care. As Picard and Robertson note, “[i]n carrying out these duties [patients] are expected to meet the standard of care of a reasonable patient. If they do not, and the breach of the standard is the factual and proximate cause of their injuries, they are contributorily negligent and their compensation will be reduced accordingly”.¹⁶ Additionally, it is always open for a court to find that the patient’s own negligence was the sole cause of his injuries, in which case the action against the defendant-physician would be dismissed.¹⁷

3. Duties and Obligations of the Plaintiff-Patient in Medical Negligence Actions — A Review of the Jurisprudence

Notwithstanding the historical reluctance of the courts to apply the defence of contributory negligence in medical negligence actions, there appears to be a newfound willingness on the part of some judges to recognize and enforce certain duties and obligations that patients must adhere to with respect to their own care. While still at a formative level, these cases collectively signify a move towards recognition of patient autonomy in actions involving contributory negligence. Arguably, these cases reflect a growing readiness on the part of courts to recognize that with heightened autonomy of patients comes heightened responsibility with respect to their own care. These duties and obligations include:

- (1) a duty to follow a physician’s instructions;
- (2) a duty to provide information to the physician; and
- (3) a general duty of the patient to act in her own best interests.

Each of these duties will be discussed in detail below.

(1) The Duty to Follow Instructions

One of the most important and recognized duties to emerge from recent lower court decisions involving the defence of contributory negligence in medical negligence actions has been the duty of the patient to follow a physician’s instructions. The duties incumbent on a patient in receiving instructions from the treating physician were described in *Wei Estate v. Dales*.¹⁸ While the court in *Wei Estate* did

16. *Legal Liability of Doctors and Hospitals*, *supra*, footnote 7, at p. 283.

17. *Ibid.*

18. *Wei Estate v. Dales*, [1998] O.J. No. 1411 (QL), 78 A.C.W.S. (3d) 1021 (S.C.); appealed and affirmed on other grounds [2000] O.J. No. 2753 (QL), 135 O.A.C. 145 (C.A.).

not deal specifically with the defence of contributory negligence, the court did articulate several principles that are pertinent to assessing the relevant patients' obligations vis-à-vis instructions provided by the physician. Specifically, the court stated:¹⁹

The patient himself [has] a responsibility not only to take the medication as prescribed but to monitor his own signs and symptoms and to comply with the request for follow-up appointments. The treating physician cannot be expected to follow-up every instruction given to a patient. The treating physician has the right to expect the patient will follow his or her instructions. If the patient disagrees with the doctor's instructions, then he has a duty to advise the doctor.

In the context of contributory negligence, these principles are best exemplified by the recent decision of the Alberta Court of Queen's Bench in *Ibrahim v. Hum*.²⁰ In *Ibrahim*, the plaintiff brought an action against the defendant physician alleging that the physician had been negligent in his post-operative care of the plaintiff, who had undergone carpal tunnel surgery on her right hand. Following surgery, the plaintiff developed reflex sympathetic dystrophy, a condition that caused significant pain.

Reviewing the evidence, the court held that the physician had breached the relevant standard of care by failing to advise the plaintiff of the importance of maintaining the use of her hand to facilitate her post-operative care, even though doing so would cause her pain. The court also found that the defendant had failed to properly follow up with the plaintiff to ensure that she underwent a program of physiotherapy to assist with her pain management. Finally, the court found that the defendant was negligent for failing to refer the plaintiff to a surgeon or neurologist when he became aware that she was not recovering as well as anticipated.

19. *Ibid.*, at paras. 108-109. For an earlier example of the duties of a patient to arrange appropriate follow-up appointments, see, for example, *Fredette v. Wiebe* (1986), 29 D.L.R. (4th) 534, [1986] 5 W.W.R. 222, 4 B.C.L.R. (2d) 184 (S.C.). In that case, the plaintiff, a 17-year-old girl, was found to be contributorily negligent for failing to re-attend for a follow-up appointment following a failed abortion.

20. [2005] 6 W.W.R. 564, 33 Alta. L.R. (4th) 323 (Q.B.). The duty to follow a physician's instructions was also discussed in *Robinson v. Sydenham District Hospital Corp.* (2000), 130 O.A.C. 109 (C.A.). In *Sydenham*, only the Court of Appeal considered the defence of contributory negligence. The appellant alleged that the trial judge erred in failing to consider this issue at trial. Although the Court of Appeal found that the trial judge should have considered the issue in his reasons, since it was raised at trial, there was not sufficient evidence on the record to support such a finding. On this point, see paras. 31-35 of the decision of the Court of Appeal.

Notwithstanding the findings of negligence against the physician, the court also found that the plaintiff was partially responsible for her damages. Evidence presented at trial revealed that the plaintiff had misrepresented the true state of her post-operative care to the defendant. Specifically, she failed to inform the physician that she was not following his advice. The plaintiff also conceded that other medical specialists had advised her to use her right hand to prevent stiffness.²¹

With these factors taken into account, the court held that the plaintiff was partially responsible for her own losses. It is instructive to note that the finding of contributory negligence was made despite the fact that the evidence indicated that the plaintiff might not have known the precise consequences of her inaction. Writing for the court, Bielby J. stated:²²

The fact that she did not know the full extent of the risks she was taking by failure [sic] to comply with these directives does not mean that she is excused from her inaction; she knew that her physicians believed she would benefit from physiotherapy and from the continued use of her right hand.

Based on the foregoing, the court apportioned damages at 25% to the plaintiff and 75% to the defendant-physician.

The principle that a patient's failure to follow a physician's instructions may constitute contributory negligence was also echoed in the decision of the Ontario Superior Court of Justice in *Rupert v. Toth*.²³ In *Rupert*, the physician treated the plaintiff for a condition he believed to be nasal polyps. During surgery, it was determined that the plaintiff did not suffer from nasal polyps, but actually inverting papilloma in the nasal cavity. The plaintiff was subsequently released, but was instructed that a CT scan would be necessary to discern the precise nature and scope of the disease. Accordingly, the plaintiff was asked to book a follow-up visit with his doctor. Evidence at trial revealed that the physician had not discussed with the plaintiff the consequences of failing to have further surgery. The CT scan was conducted and another physician partially conveyed the results to the plaintiff. This second physician instructed the plaintiff to arrange a further consultation with the defendant-physician. Evidence also revealed that the defendant flagged the plaintiff's CT results and instructed his office staff to arrange an appointment with the plaintiff. Unfortunately, neither the plaintiff nor the defendant ever

21. *Ibrahim, ibid.*, at para. 149.

22. *Ibid.* (emphasis added).

23. [2006] O.J. No. 882 (QL), 38 C.C.L.T. (3d) 261 (S.C.).

scheduled this appointment. Three years later, the plaintiff presented at his doctor's office with debilitating headaches. A second CT scan was ordered which showed a destructive lesion caused by the papilloma. The patient suffered a seizure a few days later and was hospitalized for four months until his death.

Reviewing the evidence, the court held that there was no recognized obligation on the part of a physician to pursue a patient to ensure that follow-up consultations were arranged. The court noted that, in this case, the physician had the right to expect that the patient would follow his instructions, noting that the physician/patient relationship is a two-way street.²⁴ Here the patient failed to arrange post-operative consultations, despite the fact that he was clearly instructed to do so by more than one health care practitioner. Ultimately, the defendant-physician was found to be 50% liable for failing to follow up and provide explicit instructions to the plaintiff regarding the consequences of failing to have further surgery.²⁵

The duty of a patient to follow a physician's instructions was also elaborated upon in *Patmore (Guardian of) v. Weatherston*.²⁶ *Patmore* involved a wrongful birth action by the plaintiff against her physician for negligence resulting in the birth of a child with spina bifida. In response, the defendant alleged that the plaintiff was negligent in failing to follow up with the defendant in a timely fashion. Specifically, the defendant argued that the plaintiff was negligent in failing to attend for a standard prenatal check-up at the 16-week mark of her pregnancy.

The plaintiff had attended at the defendant physician's office suspecting that she was pregnant. The defendant confirmed this suspicion and ordered a routine ultrasound. The results of the ultrasound revealed that the fetus was viable and the plaintiff was eight and a half weeks into her term. These results were communicated to the plaintiff by phone, at which point she was also told that she would be afforded with the opportunity to undergo a second ultrasound at the 16-week mark of her pregnancy. Evidence presented during the trial confirmed that it was the defendant's standard practice to offer a routine ultrasound at this time. Additionally, a finding of fact was made at trial that had the plaintiff attended for the routine appointment at 16 weeks, the ultrasound would have revealed the large spina bifida and afforded the plaintiff the opportunity to terminate the pregnancy.²⁷

24. *Ibid.*, at paras. 92-95.

25. We acknowledge that this holding may be inconsistent with the decision *Dumais v. Hamilton*, *infra*, footnote 49.

26. [1999] B.C.J. No. 650 (QL), 86 A.C.W.S. (3d) 981 (B.C.S.C.).

The plaintiff failed to return to the defendant's office at the 16-week mark of her pregnancy. When she did re-attend, she was slightly more than 19 weeks pregnant. In the absence of any abnormal symptoms, and two prior "uneventful" deliveries, the defendant concluded that it was too late to order an ultrasound. At that time, abortion was available in British Columbia for non-lethal reasons up until the 20-week mark of a pregnancy.

Reviewing the evidence, the trial judge held that it was the plaintiff and not the defendant who should bear the responsibility for the missed ultrasound. To this end, it is instructive to note that the court did not undertake a strict application of the defence of contributory negligence, but rather characterized the issue to be determined as *whether the plaintiff or the defendant was responsible for the failure to obtain a second ultrasound at 16 weeks.*²⁸ For her part, the plaintiff alleged that she was under the impression that a nurse would telephone her to remind her of the subsequent appointment. The plaintiff also asserted that she had been to the defendant's office in the interim period while he was away on holiday.

On grounds of credibility, the court rejected the plaintiff's contention that she had attended at the defendant's office while he was away on holiday. The court also went on to find that it was the plaintiff and not the defendant who should carry the responsibility for the missed ultrasound. Specifically, the court stated:²⁹

I find that the plaintiff was told on August 17 about the positive results of the ultrasound (and her new due date), the need for a second routine ultrasound at 16 weeks, and that she was expected to see the doctor next on September 15. Even if she failed to absorb the latter due to her worry over the previous week as to the health of the child she was carrying, she was well aware of the usual timing for follow-up prenatal visits. The onus had shifted to her. She has not established any fault on the part of the Dr. Weatherston for her failure to visit him again until October 28, 1994, by which time, the gestational age of the fetus she was carrying was over 19 weeks.

The obligation to follow the instructions of a physician, and specifically, the duty of a patient to arrange appropriate follow-up consultations when instructed to do so, was reinforced in *Atack v. Castle*.³⁰ *Atack* involved an action by the plaintiff, who himself was a neurologist, against the defendant, an orthopaedic surgeon. After a skiing accident, the plaintiff underwent hip replacement surgery,

27. *Ibid.*, at para. 11.

28. *Ibid.*, at para. 3a.

29. *Ibid.*, at para. 21.

30. (2003), 122 A.C.W.S. (3d) 1155, WL 32421 (Ont. S.C.).

performed by the defendant. The allegation of negligence related not to the defendant's diagnosis, nor to the surgery, but rather, to the quality of his post-operative care.

In response, the defendant-physician pleaded that the plaintiff was negligent in failing to seek follow-up treatment when he continued to suffer following the hip replacement surgery. Agreeing with the defendant's position, the court held that the plaintiff's failure to properly attend to his post-operative care was the sole cause of his loss. Writing for the court, Justice Power noted:³¹

In my opinion, the failure of a patient to return for a scheduled appointment, or to seek further assistance from his/her physician, or another physician, where no specific appointment is made may constitute a defence to an allegation of professional negligence in a case where damages are alleged to flow from the pain and suffering resulting from non-treatment, or at the least, may constitute contributory negligence on the part of the patient.

The circumstances in which a patient will be held responsible for his failure to arrange follow-up appointments where necessary were also discussed in *Cottrelle v. Gerrard*.³² In *Cottrelle*, the plaintiff brought an action against her family physician for damages resulting from the amputation of her left leg below the knee. Evidence presented during the trial revealed that the plaintiff, a 54-year-old woman, had been diagnosed as a non-insulin-dependent diabetic in her early 20s. The plaintiff's former physician passed this information on to the defendant when he retired in 1988. Upon transferring the plaintiff's file, the former physician informed the defendant that the plaintiff's diabetes was not well controlled. Evidence also revealed that the plaintiff was resistant to the idea of taking insulin to treat her diabetes.³³

In April of 1993, the plaintiff became aware of a sore between the third and fourth toe of her left foot and spoke to the defendant's receptionist. On the basis of the information provided, the defendant prescribed the plaintiff with Kenelog cream. Medical records revealed that the defendant examined the plaintiff three times in May 1993, but only on one occasion did he examine her left foot. Following this examination, the defendant prescribed another cream. In June 1993, the plaintiff awoke due to pain and throbbing between her toes. She subsequently attended at a nearby hospital

31. *Ibid.*, at para. 206 WL (emphasis added).

32. [2001] O.J. No. 5472 (QL), 111 A.C.W.S. (3d) 355 (S.C.); revd on other grounds 67 O.R. (3d) 737, 233 D.L.R. (4th) 45, 178 O.A.C. 142 (C.A.), leave to appeal to S.C.C. refused 236 D.L.R. (4th) viii.

33. *Ibid.* (headnote).

where an emergency physician examined her. The emergency physician diagnosed an ulcer and provided the plaintiff with antibiotics. This physician also instructed the plaintiff to return to the emergency department or visit her family physician if her situation deteriorated. The plaintiff next visited the defendant at the beginning of July, at which time her foot was so swollen she was not able to wear a shoe, or to walk normally. The defendant did not examine the plaintiff's foot, but rather referred her to a dermatologist.

Approximately two weeks later, the plaintiff attended at the emergency department of her local hospital. The emergency physician noted an odour emanating from the foot and the presence of black tissue, indicating the presence of bacteria. The emergency physician concluded that the foot was infected and that the infection was spreading proximally, and because of this, the plaintiff's leg should be amputated below the knee. The plaintiff did not hear from the defendant until she was recovering from her amputation, when his office called to book the appointment with the dermatologist.

The plaintiff subsequently brought an action against the physician for the losses she incurred as a result of the amputation of her left leg. Specifically, the plaintiff alleged that the defendant had failed to diagnose properly her condition, and that he was negligent in failing to examine her foot when she attended at his office in July 1993. In response, the defendant submitted that the plaintiff was contributorily negligent for her loss. Specifically, the defendant argued that the plaintiff was negligent in her own care, as she understood the complications of diabetes and the importance of foot care. The defendant also argued that the plaintiff was at fault for her failure to return to the defendant's office or attend at the emergency department when her symptoms began to deteriorate and the foot began to develop an odour.³⁴

Reviewing the evidence, the trial judge held that the defendant was negligent in his treatment of the sore and in his failure to examine the plaintiff's foot in July 1993. Notwithstanding this finding, the trial judge also found that the plaintiff was partially responsible for her losses. Specifically, the court held that the plaintiff should have returned to the emergency department when her foot began to worsen following the visit to the defendant-physician in July 1993. The trial judge concluded that the plaintiff should have sought treatment "when her foot began to darken and develop an odour".³⁵

34. *Ibid.*, at para. 73.

35. *Ibid.*, at para. 77.

Accordingly, the trial judge ordered a reduction in damages of 20% to account for the plaintiff's negligence.³⁶

As the cases of *Ibrahim*, *Atack* and *Cottrelle* illustrate, one of the specific duties that the courts have recognized as being subsumed under the duty to follow instructions is a duty on the patient to attend for follow-up treatment when instructed to do so by the physician. The Ontario Superior Court of Justice in *Georghiades v. MacLeod* elaborated upon this principle.³⁷

In *Georghiades*, the plaintiff brought an action against the defendant, an emergency physician, for damages sustained as the result of undiagnosed appendicitis. Specifically, the plaintiff alleged that the defendant was negligent in failing to provide adequate discharge instructions. Evidence presented at the trial indicated that the plaintiff had been born with thalassemia, a genetic blood disorder in which insufficient haemoglobin is produced, causing anaemia. The plaintiff was later diagnosed with membranous glomerulonephritis, a condition causing deterioration of the kidney. This condition was subsequently monitored by the plaintiff's family physician.

The plaintiff's condition remained stable for many years, however, in 1998, the family physician observed a further decline and referred the plaintiff to a nephrologist. The nephrologist confirmed a diagnosis of renal disease and implemented a treatment plan. The family physician's notes from January 2000 indicated that the possibility of a kidney transplant was discussed with the plaintiff, although the plaintiff later testified that he did not specifically recall this conversation.

In March 2000, the plaintiff felt unwell and attended the emergency department where the defendant diagnosed him with pyelonephritis, a kidney infection, and provided a prescription. Over the next few days, the plaintiff's condition worsened, and at some point, his appendix ruptured. The plaintiff immediately returned to the emergency department and was seen by a different physician and referred to a surgeon. Emergency surgery was performed to remove the liquefied appendix and cleanse the abdomen of the widespread infection. The plaintiff spent the next five days in intensive care and a total of 21 days in the hospital. On account of the kidney malfunction,

36. *Ibid.*, at paras. 73-77. Justice Leitch rejected the defendant's submission that contributory negligence should account for a 40-60% reduction of the plaintiff's damages. This rejection was based primarily on the trial judge's finding that the relationship between the plaintiff and the defendant had "broken down" following the July visit, and that the plaintiff perceived that the defendant had been dismissive of her condition.

37. [2005] O.J. No. 1701 (QL), 138 A.C.W.S. (3d) 1185 (S.C.).

the plaintiff also commenced emergency dialysis. Despite this, his kidneys did not recover. A regular program of dialysis continued for approximately one year until transplant surgery was performed.

In reviewing the evidence, the court held that the emergency physician was negligent in failing to provide adequate discharge instructions to the plaintiff. The court noted that these instructions should have included a rationalization of his diagnosis and an explanation of the steps to be taken should the plaintiff's condition deteriorate.

Despite this, the court found contributory negligence on the part of the plaintiff, and ordered a 25% reduction in the award. Specifically, the court accepted the defendant's submission that the plaintiff's failure to adequately monitor his kidney disease, and to follow up with a specialist as instructed by his family physician contributed to his loss. The plaintiff testified that he had trusted his physician's diagnosis and had not returned to the hospital when his condition worsened on the basis of this trust. Rejecting this submission, the court stated:³⁸

Given his past experiences with physicians and his disbelief of the diagnosis presented by Dr. MacLeod, it is not reasonable to accept Mr. Georghiades' statement he now trusted the doctor and relied only on his advice. Such would be an abdication of his own responsibility to himself. He ignored the recommendations from his girlfriend and family. They chose not to compel his return to hospital [*sic*]. Mr. Georghiades waited even beyond the time period stated by Dr. MacLeod for the medication to become effective. He must, therefore, bear some liability for his own action.

The Ontario Superior Court of Justice decision *Anderson (Litigation Guardian of) v. Nowaczynski*³⁹ also illustrates the duty that is placed on a patient to follow a physician's instructions. In *Anderson*, the plaintiff consulted the defendant after experiencing shortness of breath and chest pains. Although the plaintiff had a family history of heart disease, the defendant diagnosed the plaintiff with muscle pain. Months after consulting with the defendant, the plaintiff suffered a massive heart attack. She subsequently brought an action for negligence against her doctor for the misdiagnosis of her coronary artery disease.

Expert evidence presented during the trial indicated that the defendant had met the relevant standard of care and had taken all reasonable and appropriate steps in his diagnosis. Medical evidence

38. *Ibid.*, at para. 147.

39. [1999] O.J. No. 4485 (QL), 93 A.C.W.S. (3d) 170 (S.C.).

revealed that the plaintiff's symptoms of cardiac problems were absent at the time of the defendant's diagnosis, thereby allowing for the diagnosis that was ultimately reached.

Despite the finding that the defendant had not breached the relevant standard of care, the court went on to consider the plaintiff's contributory negligence in this case. Specifically, the court considered the effect of the plaintiff's failure to take the defendant's advice and seek medical attention should her condition worsen. Commenting on this failure, the court observed:⁴⁰

The onus of proving contributory negligence rests with the defendant physician. *Patients have a general duty to follow instructions and to generally act in their own best interests. If they do not do so, and if the breach of this standard is the factual and proximate cause of their injuries, they can be found to be contributorily negligent . . .* Ms. Anderson failed to follow Dr. Nowaczynski's instructions to seek further medical attention when the problem worsened. In fact, the evidence is that in the late summer of 1995, Ms Anderson suffered a serious episode of shortness of breath, which required her to lie down for approximately one hour. That episode would have reasonably constituted a serious warning upon which Ms. Anderson regrettably did not act . . . Although Dr. Nowaczynski's diagnosis of costochondritis would obviously have been quite reassuring to Ms. Anderson, it does not excuse the sad reality that Ms. Anderson had some responsibility to act prudently in her own best interests by re-attending at Dr. Nowaczynski's office or at another physician's office [should her condition deteriorate].

Based on the foregoing, the court held that had negligence been found against the physician, the court would have apportioned liability at 75% to the defendant and 25% to the plaintiff.⁴¹

(2) The Duty to Provide Information to the Physician

Along with promulgating a general duty to follow a physician's instructions, recent medical negligence cases involving the defence of contributory negligence also indicate that there may be increasing obligations on the part of the patient to provide complete, relevant information to the treating physician. While the case law in this area is admittedly sparse, there is certainly room for further development of this duty in future cases. Such development may be based on the reasonable expectation that a patient will provide his physician with an accurate medical history, including information related to the

40. *Ibid.*, at para. 212.

41. *Ibid.*, at para. 213.

onset of symptoms, a description of the symptoms, and a list of prescribed medications, if any.

The duty to provide information to the physician was succinctly explained by the Alberta Court of Queen's Bench in *Rose v. Dujon*.⁴² In *Rose*, the plaintiff was involved in a motor vehicle collision where he sustained injuries to his neck and back. In the months following the collision, the plaintiff suffered two further incidents of head trauma. During visits to the defendant-physician, the plaintiff failed to disclose these multiple incidents of head trauma, nor did he inform his physician that he was experiencing severe headaches, dizziness and blurred vision. On the basis of the information available, the physician arrived at a diagnosis of viral gastritis. The plaintiff was later diagnosed with papilledema, a condition that subsequently precipitated the onset of blindness. At trial, it was agreed that had the plaintiff been diagnosed earlier, his sight could have been saved.

Counsel for the plaintiff argued that the defendant was negligent in failing to properly diagnose the plaintiff's illness in a timely fashion, and in not referring him to a specialist.⁴³ In response, counsel for the defendant argued that the plaintiff was contributorily negligent for failing to inform the defendant of his symptoms and of the subsequent incidents of head trauma.

Dismissing the action against the physician, the court explained the precise nature and scope of the duty of care owed by a patient in disclosing all relevant medical information to a physician. Writing for the court, Justice Fraser stated:⁴⁴

The duty a patient owes to himself is to do everything reasonably necessary to ensure he is not harmed, failing which he exposes himself to the submission that he has been contributorily negligent in the losses suffered by him. That being so, surely it is reasonable in discharging the duty of care a patient owes to himself that the patient should be held responsible and accountable for disclosing to his doctor all relevant and pertinent information of which he is aware in order to permit his doctor to make a proper diagnosis. Both parties in the doctor-patient relationship have obligations — the doctor to the patient and the patient to himself — and inherent in the discharge of such obligation is the need to communicate fully with each other. *To be effective, communication must be bilateral. Doctors are not mind readers and it would be unrealistic and unfair to treat the doctorpatient [sic] relationship as one in which the doctor were constantly being tested to see if he could*

42. [1990] A.J. No. 844 (QL), 108 A.R. 352 (Q.B.).

43. *Ibid.* (headnote).

44. *Ibid.* at p. 21 (emphasis added).

solve the patient's medical problems with limited or no relevant information from the key source — the patient.

As the decision in *Rose* indicates, courts have been willing to place significant weight on a patient's failure to provide full and frank disclosure to the physician when assessing liability and damages. This was also demonstrated in the recent decision of the Newfoundland and Labrador Supreme Court, *Ross Estate v. Hiscock*.⁴⁵

In *Ross Estate*, the family of the deceased commenced an action against an emergency physician for his alleged misdiagnosis of an aortic dissection. The deceased, a pregnant woman, attended the hospital after experiencing acute chest pains. During this initial visit, the deceased failed to disclose that she had a significant family history of heart disease. She also failed to reveal to the treating physicians that she had previously been diagnosed with Marfan syndrome, a condition that caused degeneration of the aortic wall. She was admitted and observed for two days, following which she was discharged. A week later, she re-attended, again complaining of severe chest pain. She was subsequently transferred to a tertiary care centre where surgical intervention was unsuccessful and she died. The child was delivered by caesarean section, but also died due to complications related to the mother's condition.

Reviewing the evidence, the court held that a treating physician could not be held negligent when a patient deliberately conceals relevant history that would significantly alter the physician's diagnosis. Reviewing the evidence, the court maintained that during both visits to the emergency department, physicians had asked the deceased whether there was a family history of heart problems and whether she was suffering from any medical problems. On both occasions, the deceased failed to answer truthfully, fearing that if she did, this would prompt further testing. Taking these factors into account, the court stated:⁴⁶

A patient owes a duty to herself to do everything reasonably necessary to ensure that she is properly diagnosed by her physician. As part of that duty, the patient must disclose to the physician all relevant and pertinent information in order to permit the physician to make a proper diagnosis of her medical condition.

While there has not been a considerable amount of jurisprudence related to the duty to provide information to the physician, the cases

45. [2006] N.J. No. 76 (QL), 254 Nfld. & P.E.I.R. 319 (Nfld. & Lab. S.C.T.D.), affd 262 Nfld. & P.E.I.R. 343 (C.A.).

46. *Ibid.*, at para. 118 (emphasis added).

above provide a firm foundation for the expansion of the duty through future jurisprudence. Both *Ross Estate* and *Rose* evidence the principle that the failure of a patient to disclose pertinent information to the physician will weigh heavily in the apportionment of damages, especially where it was reasonable for the physician to rely on the patient's reported medical history or lack thereof. Indeed, in both cases, the actions against the defendant-physicians were dismissed in their entirety. Applying general principles of negligence law, it follows that a patient will be found contributorily negligent where there is a failure to disclose and/or accurately disclose relevant information to the physician which is reasonably relied upon and results in a negative outcome for the patient, whether it be a delayed or inaccurate diagnosis, or an adverse reaction or complications.

(3) The General Duty of the Patient to Act in His Own Best Interests

Along with the duty to follow instructions and the duty to provide information, there is developing authority within the context of the defence of contributory negligence that provides for a general duty on patients to act in their own best interests. The duty of a plaintiff to act reasonably is not a novel proposition. Indeed judicial pronouncements to this effect have been evident in the case law for some time. A case that is often cited in this respect is the decision of the British Columbia Supreme Court in *Crossman v. Stewart*.⁴⁷ *Crossman* involved a claim for damages by the plaintiff against her dermatologist. The plaintiff was diagnosed with discoid lupus erythematosus, a facial skin disorder, and had been prescribed a drug called chloroquine for the purpose of treatment. The defendant saw the plaintiff five times over a five-month period and on all but one occasion had provided the plaintiff with further prescriptions for the drug. When the last prescription was complete, the plaintiff obtained the drug from a salesman who supplied the doctor for whom she worked as a receptionist. By this method, she was able to obtain the drug at one-half of the price payable to the pharmacy, and without the need for a prescription. The defendant did not know that the plaintiff was obtaining the medication in this manner.

Meanwhile, the defendant-physician attended a seminar where he was informed about the risks of long-term use of the drug that had been previously prescribed to the plaintiff. In some cases, patients developed damage to the retina that caused blindness or near-blindness. Upon returning from the seminar, the defendant consulted

47. (1977), 82 D.L.R. (3d) 677, 5 C.C.L.T. 45 (B.C.S.C.).

with all the patients to whom he had prescribed the drug, including the plaintiff, and arranged for them to have eye examinations. The plaintiff's eye examination revealed some corneal changes, which indicated recent use of the drug. Despite this, the plaintiff was told that the results of her eye examination did not indicate any damage to the retina.

The plaintiff continued to take the drug for another two years, acquiring it through the salesman until he retired. Once the salesman retired, the plaintiff returned to the defendant, who prescribed the drug for another six months. The defendant provided the prescription without the knowledge that the plaintiff had been taking the medication continuously for the previous two years. Subsequently, retinal damage was discovered in the plaintiff's eyes, resulting in near total blindness.

The court apportioned liability at two-thirds to the plaintiff and one-third to the defendant. In so doing, the court explained what a reasonable person in the plaintiff's position should have known, and stated:⁴⁸

While a reasonable patient is not required to possess special knowledge relating to the specific risks involved in using "prescription" drugs it seems to me that ordinary common sense would dictate that it is foolhardy in the extreme to do the following things:

To obtain "prescription" drugs from an unorthodox source.

To continue to use drugs on a prolonged basis without obtaining "prescription" renewals.

To continue to use drugs on a prolonged basis without consulting the "prescribing" physician (In this case almost two years).

With respect to the issue of apportionment of liability, the court held:⁴⁹

In my view, this not a case where the apportionment of blame is so difficult that liability should be apportioned on a 50/50 basis. I hold that the plaintiff must take the major share of the blame for the tragic plight in which she finds herself. If the plaintiff had acted with any reasonable degree of prudence the permanent damage to her eyes would not have resulted. The defendant's failure to take the high standard of care was one of the causative factors but not the major cause. In these circumstances I hold the plaintiff was two-thirds to blame and the defendant one-third to blame.

Other cases following *Crossman* have emphasized the patient's duty to act reasonably. Moreover, it appears that recent cases have been

48. *Ibid.*, at paras. 66-69.

49. *Ibid.*

more willing to hold patients to a higher standard of care than would have traditionally been the case. This is evidenced in cases such as *Dumais v. Hamilton*,⁵⁰ a decision of the Alberta Court of Appeal.

Dumais involved an appeal by the defendant-physician from a trial judgment that had awarded the plaintiff damages on the basis of the physician's failure to adequately warn her of the possibility of skin loss following a "tummy tuck" operation.⁵¹ One of the grounds for the appeal was that the trial judge had failed appropriately to consider the role of the patient's own actions in contributing to her loss. Specifically, the Alberta Court of Appeal considered whether the patient was negligent because she continued to smoke following her surgery, notwithstanding instructions from the defendant-physician to refrain from doing so on more than one occasion.⁵²

The Court of Appeal noted that there was clear evidence that the patient's post-operative smoking contributed to her skin loss, even though the extent of this contribution was unknown. The trial judge concluded that a reasonable person in the patient's position should not be taken to have known that her actions were likely to contribute to her injuries.⁵³ The Court of Appeal noted that the trial judge reached this conclusion on the basis that the defendant had not informed the patient of the precise reason for telling the plaintiff to refrain from smoking following surgery.

Rejecting this line of reasoning, the Court of Appeal held that the trial judge had misapprehended the nature of the analysis applicable in this case. Specifically, the Court of Appeal noted:⁵⁴

With respect, in our view the trial judge erred in suggesting that Dumais could only be found to be contributorily negligent by smoking if she reasonably knew the nature and character of the potential injuries that could result. The proper question to ask is whether she took reasonable care of herself in circumstances . . . In this case, she persisted in smoking after the operation, despite clear and repeated advice from Dr. Hamilton that she should not do so. In our view that behaviour was not reasonable.

Accordingly, the court held that the plaintiff was contributorily negligent by continuing to smoke following her surgery. Because the court could not determine the extent to which the smoking had contributed to the plaintiff's loss, damages were apportioned at 50%

50. [1998] A.J. No. 761 (QL), 179 W.A.C. 63, 219 A.R. 63 (Alta. C.A.).

51. *Ibid.*, at para. 15.

52. *Ibid.*

53. *Ibid.*

54. *Ibid.*, at para. 16 (emphasis added).

to the defendant and 50% to the plaintiff, pursuant to s. 1 of Alberta's *Contributory Negligence Act*.⁵⁵

The duty of a patient to act in his/her best interests was also discussed by the British Columbia Supreme Court in *Zhang v. Kan*.⁵⁶ *Zhang* involved an action by the plaintiff against her physician for negligence resulting in the birth of a child with Down's Syndrome. The plaintiff was 37 years old when she became pregnant. After consulting with her physician in Hong Kong, the plaintiff was informed that on account of her age she was at a heightened risk of delivering a child with Down's syndrome. Following this consultation, the plaintiff travelled to Vancouver to consult with the defendant regarding her pregnancy. During this meeting, the plaintiff requested an amniocentesis. The defendant incorrectly stated that it was "too late" to have the test. Several months later, the plaintiff delivered a child with Down's syndrome.

The British Columbia Supreme Court found that the defendant was negligent in informing the plaintiff that an amniocentesis was not available. Evidence presented during the trial revealed that the defendant could have ordered an amniocentesis in an expedited fashion. The court noted that this procedure would have alerted the plaintiff to the fact that the foetus had Down's syndrome, and would have afforded her the opportunity to terminate the pregnancy.

Notwithstanding the finding of negligence on the part of the defendant, the court also found that the plaintiff was partially responsible for her failure to have an amniocentesis during her pregnancy. The court noted that the plaintiff was a "sophisticated and experienced businesswoman" who had conducted research on the topic of amniocentesis. The court also displayed scepticism to the plaintiff's submission that she trusted the defendant's position that it was "too late" to have an amniocentesis performed. Specifically, the court noted:⁵⁷

Ms. Zhang said she doubted Dr. Kan's advice that it was too late to take the test. She told Mr. Fung so. He told her to trust Dr Kan because he was a doctor [. . .] Ms. Zhang, who was not yet married to Mr. Fung, appears reluctantly to have accepted Mr. Fung's suggestion that she trust the doctor. But she knew from what she had read and from what [her family

55. *Ibid.*, at para. 17. Section 1 of Alberta's *Contributory Negligence Act*, R.S.A. 1980, c. C-23 provides that if the extent of each party's negligence cannot be determined, liability should be apportioned at 50%. See also *Simon v. Luis*, [2000] O.J. No. 5420 (QL) (S.C.) where the plaintiff's smoking resulted in a 10% reduction in liability.

56. [2003] B.C.J. No. 164 (QL), 15 C.C.L.T. (3d) 1 (B.C.S.C.).

57. *Ibid.* at para. 62.

doctor] had said that it was not too late for amniocentesis. She agreed at trial that she could have turned around and gone back to Hong Kong and taken the test. She could certainly have sought out another doctor in Richmond, as she did two months later. Ms. Zhang was not timid about seeking medical advice. During her pregnancy she consulted five different doctors. That she blamed herself for Sherry's condition after delivery is perhaps of some relevance.

On the basis of this, the court concluded that the plaintiff should share some of the responsibility for the absence of an amniocentesis during the pregnancy. This conclusion was influenced by the plaintiff's evidence that following the visit to the defendant, she and her partner agreed that if there were a problem with the pregnancy they would "go after" the defendant. Accordingly, the court apportioned damages at 50% to the plaintiff and 50% to the defendant.

The jurisprudence discussed above indicates that the duty of the patient to act reasonably, first articulated by the British Columbia Supreme Court in *Crossman*, has found strong resurgence in recent cases. These cases reveal a newfound willingness on the part of judges to hold patients accountable for their failure to act in their own best interests. In light of the cases discussed above, it appears that courts are prepared to scrutinize the patient's behaviour independent of, and, in some cases, notwithstanding advice that the patient has received from the defendant-physician. Indeed, following the line of reasoning established by the Alberta Court of Appeal in *Dumais*, it appears that the fact that plaintiff may not be aware of the precise nature and/or consequences of her actions will not preclude a finding of contributory negligence, where her behaviour is found to be unreasonable.

4. Towards Consistency — The Application of the Defence of Contributory Negligence in Medical Negligence Actions

The latter half of the twentieth century saw the evolution of an earlier discourse of "patient self-determination" crystallize into a more assertive discourse of "patient's rights". When the Supreme Court declared in 1980⁵⁸ that physicians were to inform patients as to the risks of a given treatment, it gave legal force to the notion that patients had "rights" and doctors had "obligations". As Professor Jay Katz observes, "the newly imposed legal requirement of informed consent — the dual obligation to inform patients and to obtain their consent — is only modern proof that trust in the professional is no

58. *Reibl*, *supra*, footnote 6.

longer viewed as sufficient protection of the integrity of the physician-patient relationship".⁵⁹

Yet the move toward patient rights cannot be accomplished without simultaneously recognizing the corresponding obligations that accompany greater patient autonomy in medical decision-making. The recognition of greater patient autonomy at law mandates that courts re-evaluate the foundational assumptions upon which the majority of medical law is premised. In the context of the defence of contributory negligence, this means that courts must move away from the implicit assumption of patient dependence; an assumption that, for decades, justified the preclusion of the defence of contributory negligence for defendant-physicians. In other areas of medical law, such as the law of consent to treatment, the courts and the legislatures have acknowledged patient autonomy and have taken steps to empower patients to assume a more active, even a proactive role, in medical decision-making.

The question remains, however, about whether the courts and legislatures have been consistent in articulating a doctrine of "patients' rights" without issuing a correlative doctrine of "patients' obligations" in the discharge of one's own medical care. There is an argument to be made that the movement for patients' rights demands reciprocity. For example, if patients have the "right" to full disclosure by their physicians, then it can be argued that they also have the "obligation" to reciprocate by fully and accurately disclosing to the physician all information that may be relevant to the patient's medical care.

The cases discussed above suggest that courts are gradually working to incorporate a doctrine of patient obligations into medical jurisprudence. As we have seen, however, in the context of contributory negligence, this process has been far too slow in its development and acceptance as compared to general negligence law. Accordingly, steps must be taken actively to move towards a coherent model of patient autonomy—one that recognizes that greater patient participation in medical decision-making necessitates the enforcement of corresponding obligations.

5. Conclusion

Historically, defendant-physicians attempting to advance the defence of contributory negligence faced much resistance. A perceived power imbalance coupled with the physician's specialized

59. See Jay Katz, *The Silent World of Doctor and Patient* (New York: MacMillan Inc., 1984), p. xiv.

knowledge led many courts to set the standard of care that the patient must adhere to at an unreasonably low level. In a society where physicians were to be trusted implicitly, patients had little, if any, duty to go beyond the medical instructions provided by physicians.

Several factors have contributed to a change in the basis of the physician-patient relationship at law. In light of these changes, and the primacy that courts have placed on patient participation in medical decision-making, it is no longer tenable to continue effectively to preclude the defence of contributory negligence for defendant-physicians. As many health law commentators have observed, the most likely consequence of enforcing the corresponding obligations that accompany patient rights will be an improvement to the overall quality of care.⁶⁰ In this way, "collaboration and informed trust are reinforced by both parties . . . [patients] are held to a higher standard of communication and cooperation, and professionals are faced with an informed and active participant".⁶¹ Indeed, as Canadian courts have begun to acknowledge, the physician-patient relationship is a "two-way street" in which both parties are imbued with certain rights and obligations.

60. John O. Beahers, "Legal Duties of Psychiatric Patients" (1990), 18 Bull Am. Acad. Psychiatry L. 189 at pp. 193-94 cited from Sharon Murphy, "Contributory Negligence in Medical Malpractice: Are the Standards Changing to Reflect Society's Growing Health Care Consumerism?" (1991-1992), 17 U. Dayton L. Rev. 151 at p. 178.

61. *Ibid.*