Contributory Negligence in Medical Malpractice Cases

INTRODUCTION

Medical malpractice cases sometimes involve deeply personal issues involving the plaintiff’s behaviours and beliefs. As advocates it can be easy to downplay or even entirely overlook the client’s responsibility to protect themselves from harm. When you first meet a potential client and consider both the likelihood of success and the potential compensation for damages suffered, you must consider the potential for a contributory negligence defence, which can have a significant impact on the outcome of your case.

Over recent decades, there has been an increasing movement towards recognition of patients’ rights and autonomy, but along with increasing rights come increasing responsibilities:

Patients have certain duties and responsibilities when seeking medical treatment, including a duty to provide information, to follow instructions, and generally to act in their own best interests. In carrying out these duties they are expected to meet the standard of care of a reasonable patient. If they do not, and the breach of this standard is the factual and proximate cause of their injuries, they are contributorily negligent and their compensation will be reduced accordingly. Of course, if the injury is due exclusively to the patient’s own negligence, the action will be dismissed.


In this paper, we will examine when a plaintiff’s actions (or inactions) have contributed to their injury, and the implications of a finding of contributory negligence.

FAILURE TO PROVIDE INFORMATION TO THE PHYSICIAN

One of the key steps in a physician’s assessment of a patient’s complaint is taking a medical history. The information provided by a patient can help guide a physician’s diagnosis and treatment plan, and can assist in monitoring that treatment plan. The court in *Rose v. Dujon*, 1990 CanLII 5950 (AB QB) described the patient’s role in providing information:

[148] … 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 obligations 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 doctor-patient relationship as one in which the doctor were constantly being tested to see if he could solve the patient’s medical problems with limited or no relevant information from the key source — the patient. Diagnostic testing in a vacuum is time-consuming, costly and inefficient.

In *Rose* the plaintiff suffered subdural hematomas two and three weeks before they were diagnosed. These hematomas caused increased pressure in the brain that ultimately lead to blindness. The plaintiff suffered two traumatic blows to the head in the weeks leading up to the diagnosis of the hematomas, and had not mentioned this to his treating physicians. Despite a finding that none of the physicians involved in the plaintiff’s care were negligent, the court went on to consider the plaintiff’s duty to himself, and his role in contributing to his injury. The court noted:

[148] … 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. … (T)he 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.

It can be difficult for a patient to know which of their signs and symptoms or aches and pains may be “relevant and pertinent”
without being asked specific questions. The *Rose* court acknowledged this issue, but still placed a high degree of responsibility on the patient:

[149] Of course, one must always remain sensitive to the nature of the doctor-patient relationship and the fact that such relationship may well be intimidating for many patients. As well, it is beyond dispute that a patient’s ability to fully disclose all relevant facts to his doctor will necessarily depend upon the individual patient and the extent to which that patient is able, by reason of his personal circumstances, education, ability and level of insight, to make such disclosure. However, notwithstanding these limitations, I raise for consideration whether a patient should nonetheless be obliged to disclose all such relevant information of which he is cognizant to his doctor …

In *Bennett v. Landecker*, 2011 ONSC 6168 (CanLII), the court found that the plaintiff did not do everything reasonably necessary to ensure he was not harmed, and therefore could not be absolved of responsibility in the doctor/patient relationship. The plaintiff suffered an acute loss of vision in the upper left visual field, and sought immediate medical attention. He was diagnosed with a retinal arterial occlusion and was told the problem was created by an embolus and that there was therefore nothing further that could be done. The plaintiff interpreted this to mean that no matter what the circumstances his physician could no longer assist him. Within two days of this partial visual loss, the plaintiff experienced a total loss of vision in his left eye. It was nearly two months before he brought this total loss of vision to the attention of his physician, despite seeing physicians for other health problems over that time period. He was ultimately diagnosed with a retinal detachment which would likely not have resulted in blindness had it been treated earlier.

The court found that the physician fell below the acceptable standard of care in several respects, but the plaintiff shared 40 per cent of the negligence. The court found that the plaintiff had an obligation to act pro-actively in his own interests; to call his physician, attend at his office without an appointment (as he had done in the past), go to emergency or take other steps to ensure that the drastic change in his vision was communicated to a physician. In failing to take these steps the plaintiff’s actions deviated not only from the standard of a reasonable patient, but also from the plaintiff’s own previous behaviour.
FAILRE TO COMPLY WITH MEDICAL INSTRUCTIONS

A patient’s failure to follow a physician’s advice or instructions may constitute contributory negligence. The cases take a different approach to the issue depending on whether or not the patient understood the reason for the instructions. This failure to follow advice could be a failure to return for follow-up appointments, or a failure to attend for additional testing.

In Polera v. Wade, 2015 ONSC 821 (CanLII) the plaintiff was experiencing hearing loss in her right ear. She was tested and fitted with a hearing aid, and was sent for an MRI. When the MRI results came back, the defendant failed to detect Ms. Polera’s brain tumour. He admitted liability but advanced a contributory negligence defence because the plaintiff had failed to keep the follow-up appointments that were recommended. The judge found that while the plaintiff had indeed failed to make the follow-up appointments and did not attend at an ‘emergency appointment’ (the plaintiff had not been advised there was any emergency), she knew nothing about the brain tumour. She was not told there was any urgency in seeing the physician and had no reason to understand that failing to attend appointments was critically important. It seems then that the patient’s understanding of the reason for follow-up can have a significant effect on whether they may be faulted for any harm that they suffered.

The courts took a different view on a patient’s lack of follow-up in Kahlon v. Vancouver Coastal Health Authority, 2009 BCSC 922 (CanLII). Here, the plaintiff suffered from lower back pain. Two physicians told him that it was likely disc related; a benign condition that would recover with time and exercise. However, he had a CT scan of his lumbar spine that revealed possible problems and the radiologist asked the hospital staff to contact the plaintiff and have him return for an additional CT scan with contrast. The plaintiff did not return for that scan and subsequently became seriously ill with an infection leading to a brain injury. Although the plaintiff told his family physician that he did not return for the follow-up CT with contrast because he did not want dye injected into his body, the court found that he likely simply procrastinated, relying on the working diagnosis of the physicians that he had a benign disc or muscle problem.

Finding that his misunderstanding of the cause of his back pain was in part a consequence of his own actions in failing to follow-up as he had been instructed, the court determined that the plaintiff should bear some liability for the outcome. The court noted that a patient’s understanding of his condition and of the potential risks of not following up were relevant contextual factors to be considered in determining his contribution to the injury, and assessed the plaintiff’s contributory negligence at 30%.

Can a patient fail to meet the standard of a reasonable patient by following a doctor’s advice? That was the result in Zhang v. Kan, 2003 BCSC 5 (CanLII). Here, the plaintiff relied on a physician’s incorrect advice that it was too late to have amniocentesis and opted not to have the test. Because of that, she did not discover that her child had Down Syndrome and lost the opportunity to terminate the pregnancy. The court noted that she was a sophisticated and experienced businesswoman who had researched the topic of amniocentesis and knew that at her age she was at high risk of bearing a child with Down Syndrome. Her evidence at trial was that she knew from what she had read and from another physician that it was not too late for an amniocentesis test, and although she doubted the defendant physician’s advice, she elected to trust him. In the result, the court assessed the plaintiff’s contributory negligence at 50%.

THE ROLE OF MODIFIABLE RISK FACTORS

Not all plaintiffs have healthy lifestyles. So-called “modifiable risk factors” such as smoking, alcohol consumption or obesity can contribute to the harm caused by negligent medical treatment and have resulted in findings of contributory negligence.

In Dumais v. Hamilton, 1998 ABCA 218 (CanLII), the plaintiff was a smoker who had an abdominoplasty (tummy tuck) and sued her physician for failing to warn her that the procedure could result in a loss of skin. She was repeatedly warned by the defendant to cut down smoking prior to the operation and to absolutely stop for at least a week after the surgery, but the defendant doctor had not explained the reason for those warnings. The plaintiff only stopped smoking for two days while in the hospital recovering from surgery. She began smoking again upon discharge from the hospital and within 10 days developed necrotic tissue in the surgical area. Two weeks later large amounts of skin had died and.....
she had revision surgery which left her permanently disfigured. Although the trial judge dismissed a defence of contributory negligence on grounds that the defendant did not provide an explanation for the warnings, on appeal, the plaintiff was found to have contributed to her injury and was apportioned 50% liability. The appeal court found that even though the plaintiff had not been provided with an explanation as to why she should stop smoking, her behaviour was not reasonable in any case. The 50% apportionment resulted from the fact that there was no evidence offered to determine to what degree her smoking contributed to the development of the necrosis.

In Simon v. Lusis, [2000] OJ No 5420 (SCJ), the plaintiff had a recurrence of an ulcer and surgery to remove the affected portion of her stomach. The court found the defendant physician liable for failing to caution her against taking non-steroidal anti-inflammatory drugs because they could worsen her peptic ulcer. The court awarded the plaintiff $45,000 but found her to be 10% contributorily negligent for continuing to smoke against the advice that the defendant likely provided.

These cases concern the health risks of smoking, but there are other behaviours that can have a negative impact on health outcomes. Plaintiff’s counsel must be mindful of issues such as obesity, or the use of alcohol or drugs. Failing to heed a physician’s instructions regarding modifiable risk factors may have the effect of lessening an award. While it is easy for a physician to tell a patient to stop smoking or drinking or to lose weight, those changes are difficult for a patient to make. Using the example of a smoker who is about to undergo surgery, it is safe to assume that all smokers ought to know they should quit smoking. Without being provided with a specific explanation from the physician about why smoking adds additional risks to a procedure, the physician’s advice may not be persuasive. Leading expert evidence about how unlikely it is that a smoker will be able to stop smoking “on command” may assist the court in recognizing that the recommendation is not one that many plaintiffs could follow, particularly if they have not been provided with a specific explanation of how smoking can increase their risk of a bad outcome. In addition, if the negative effect of the risky behaviour is small, it could be important to provide the court with that evidence, to avoid equal apportionment of liability due to lack of evidence of the different degrees of fault.

**Implications of a Finding of Contributory Negligence**

The circumstances of a medical malpractice claim can sometimes blur the lines between contributory negligence and a failure to mitigate; even judges can get it wrong. In a decision that began with the line “Sometimes one cannot see the forest for the trees,” a judge acknowledged that his previous finding that the plaintiff was contributorily negligent and one third responsible for her damages was entirely erroneous, as were his comments about the impact of the Contributory Negligence Act on the plaintiff’s result. In fact, she was not contributorily negligent but was guilty of a failure to mitigate, and was responsible for one third of the damages that in the end she suffered (Cavanagh v. Anderson, 1995 CanLII 4524 (NS SC)).

In general terms, contributory negligence occurs prior to an injury being sustained, and the duty to mitigate arises after the injury is sustained. Although both legal concepts can result in a reduction in the plaintiff’s damages it is important to distinguish between the two, because a finding of contributory negligence carries with it additional financial implications for the plaintiff.

The provisions of the Negligence Act, RSBC 1996, c333 (the Act) figure prominently if there is a finding of contributory negligence. Section 1 of the Act describes the apportionment of liability when the plaintiff is one of the wrongdoers; joint and several liability is not available to the plaintiff if they have contributed to their injury and they can only recover from a defendant the proportion of the loss that corresponds to that defendant’s fault.

The method of determining apportionment is also set out in Section 1 of the Act; liability to make good the damage or loss is in proportion to the degree to which each person was at fault. The court in Khallou noted that an assessment of the degree of fault requires an analysis of the party’s degree of departure from the standard of care. The judge contrasted this result with what might have happened if causation had been the test, noting that he might have found equal apportionment of liability in that case. Given that the degree of fault was the test, he found that the hospital deviated markedly from the standard of care in several ways, but since the plaintiff’s conduct was simply careless, he was substantially less blameworthy than the hospital. Liability was apportioned 70% to the defendant hospital, and 30% to the plaintiff.

In addition, a finding of contributory negligence can result in a reduction in the plaintiff’s award of costs, as section 3 of the Act directs that the liability for costs is in the same proportion as the degree to which they were at fault.

Another possible financial implication of a finding of contributory negligence is the potential for the plaintiff to have to pay costs to the defendant in proportion to their share of the negligence pursuant to Rule 14-1(15) of the Rules of Court (Brooks-Martin v. Martin, 2011 BCSC 497 (CanLII)).

**Conclusion**

The imbalance of knowledge between physicians and patients will often be front and centre in medical malpractice cases. Patients often do not understand the complexities of the health care delivery system or even their own health condition. Nonetheless, they may be found to have contributed to the harm they suffered. Some authors suggest that the courts are mindful of the impact of a finding of contributory negligence on a plaintiff’s potential award, and generally keep the attribution to the plaintiff low. Nonetheless, it is important to critically assess your case for the potential of a contributory negligence defence and keep this in mind as you prepare your client for discoveries and for giving evidence at trial. This careful analysis can also assist you in managing your client’s expectations and in determining what evidence you may need to adduce at trial.