North Dakota Law Review

Volume 55 | Number 2 Article 3

1979

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CONTRIBUTORY NEGLIGENCE OR ASSUMPTION OF RISK— WHAT IS A PATIENT TO DO?

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This article will discuss three doctrines commonly found in medical malpractice cases, and analyze how they relate to one another in such a case. These three doctrines are Contributory Negligence, Informed Consent and Assumption of Risk.

Although adoption of comparative negligence has done away with the defense of contributory negligence in many jurisdictions,[1] the retention of assumption of risk still makes the study of contributory negligence in its relationship to assumption of risk an important area of study for the practicing attorney.

I. CONTRIBUTORY NEGLIGENCE

"Contributory negligence is conduct on the part of the plaintiff which falls below the standard to which he should conform for his own protection, and which is a legally contributing cause cooperating with the negligence of the defendant in bringing about the plaintiff's harm."[2] As contributory negligence is applied to malpractice cases, as elsewhere, a confusion of words exists, as described by Dean Prosser,[3] wherein some courts state that any negligence which contributes to the injury, however slight, in any degree, bares recovery.[4] Other courts state that the contribution

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1. *See, e.g.,* Krise v. Gillund, 184 N.W.2d 405 (N.D. 1971). Comparative negligence was codified in North Dakota in 1973. 1973 N.D. Sess. Laws Ch. 78 codified at N.D. CENT. CODE § 9-10-07 (1975).

2. RESTATEMENT (SECOND) OF TORTS § 463 (1965).

3. W. PROSSER, LAW OF TORTS 421 (4th ed. 1971).

4. Aitchison v. Reter, 245 Iowa 1005, 64 N.W.2d 923 (1954).

must have been substantial.[5] In all courts, however, the application of the doctrine centers upon examination of the degree to which the plaintiff's negligence contributed to the damage, and not to the extent to which plaintiff was negligent.[6]

There is one aspect in which courts have varied from their normal application of contributory negligence; when the case concerns true malpractice and not merely a suit against a health-care provider for negligence. This long-standing distinction[7] was stated by one New York court as follows:

> There are situations in actions loosely labeled malpractice where the charge of dereliction is indistinguishable from the ordinary charge of negligence. The bulk of such actions are against hospitals, but it is conceiveable that one could arise against a doctor. In such a case, applying the rule that contributory negligence defeats the action would be entirely proper. But where the gravamen of the action is the improper professional treatment, the patient's failure to follow instructions does not defeat the action. If the failure increases the extent of the injury, damages would be reduced to that degree.[8]

The rationale for this distinction appears to be based upon the principle of proximate causation.

> To constitute a bar to the suit the negligence of the patient must have been an active and efficient contributing cause of the injury. In other words, contributory negligence to defeat a right of action must be simultaneous and cooperating with the fault of the defendant, must have entered into the creation of the cause of action, and have been an element in the transaction which constituted it. Where the fault of the patient was subsequent to the fault of the physician and merely aggravated the injury inflicted by the physician, it only affects the amount of damages recoverable by the patient.[9]

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5. *See, e.g.*, West v. Martin, 31 Mo. 375, (1861), wherein it is said that "[T]he rule in such cases seems to be that if the plaintiff substantially contributed to the injury by his improper or negligent conduct, he can not recover; but if the injury was occasioned by the improper or negligent conduct of the defendant and the plaintiff did not substantially contribute to produce it, then the latter would be entitled to the verdict. *Id.* at 379.

6. W. PROSSER *supra* note 3, at 421.

7. *See, e.g.*, Fowler v. Sergeant, 1 Grant, Cas. 355 (Pa. 1856).

8. Morse v. Rapkin, 24 App. Div. 2d 24, 263 N.Y.S.2d 428 (1965).

9. 21 R.C.L. 402-03 (1918).

North Dakota is apparently, but not without question, one of the few states which does not adhere to this distinction.[10]

One of the most extreme statements of this modification was made in *Krauss v. Ballinger,*[11] in which the court stated as follows:

> If the appellants did not set the arm properly, they might be liable even if the appellee did not in every particular carry out their instructions. The appellants might also be liable if their treatment of the arm subsequent to the setting was improper, although the appellee did not in all respects carry out their instructions.[12]

One point in time at which the plaintiff may be negligent is prior to the negligence of the physician. There is some question as to whether this can constitute contributory negligence. In *Sales v. Bacigalupi,*[13] the plaintiff accidently punctured her foot with a nail, which wound she unsuccessfully treated with home remedies. The court held that the issue of such self-treatment being contributory negligence was one for the jury.[14] This is apparently in conflict with the requirement that, in order for plaintiff's negligence to be a bar to recovery, such negligence must have been "an active and efficient contributing cause of the injury occasioned by the malpractice of his physician,"[15] and the decision has led one author to make the bold assertion that in fact such authority "should dispel any notion that contributory negligence must be contemporaneous with or subsequent to the physician defendant's negligence."[16]

A case reaching a contrary conclusion is *Hibbard v. Thompson.*[17] The court in upholding an instruction which authorized the jury to find for and award to plaintiff for such of plaintiff's injuries as might be separable from those caused by his own negligence, set

10. "A patient cannot recover in an action against his physician for damages for malpractice if he has not conformed to all reasonable directions of such physician or if his conduct has contributed to the injury upon which the action is based." McDonnell v. Monteith, 59 N.D. 750, 756, 231 N.W. 854, 857 (1930). *See also* Hanson v. Thelan, 42 N.D. 617, 173 N.W. 457 (1919) where the rule was stated that "the patient must not have contributed to his injury in any degree; that he must conform to all reasonable directions of his physician, otherwise he cannot recover." *Id.* at 621, 173 N.W. at 458. *But see* Halverson v. Zimmerman, 60 N.D. 113, 232 N.W. 754 (1930), decided two months after *McDonnell,* in which although the court's discussion of the facts emphasized and centered upon the plaintiff having followed all of the defendant's directions, the above quoted statement from Ruling Case Law was cited with apparent approval. And see Annot., 50 A.L.R.2d 1043 at 1056 (1956), which cites *Halverson* as following the majority rule.

11. 171 Ill. App. 534 (1912).

12. Krauss v. Ballinger, 171 Ill. App. 534, 539 (1912).

13. 47 Cal. App. 2d 82, 117 P.2d 399 (1941).

14. Sales v. Bacigalupi, 47 Cal. App. 2d 82, ____, 117 P.2d 399, 402 (1941).

15. Annot., 50 A.L.R.2d 1043, 1046 (1956).

16. *Contributory Negligence as a Defense to Medical Malpractice in California,* 8 U.S.F.L. REV. 386, 396 (1973).

17. 109 Mass. 286 (1872).

forth its reasoning for this limitation to the general rule by explaining as follows:

> It is an important limitation; for a physician may be called to prescribe for cases which originated in the carelessness of the patient; and though such carelessness would remotely contribute to the injury sued for, it would not relieve the physician from liability for his distinct negligence, and the separate injury occasioned thereby. The patient may also, while he is under treatment, injure himself by his own carelessness; yet he may recover of the physician if he carelessly or unskillfully treats him afterwards, and thus does him a distinct injury. In such cases, the plaintiff's fault does not directly contribute to produce the injury sued for.[18]

This same reasoning was applied by the court in *Josselyn v. Dearborn,*[19] in which there was disputed evidence that plaintiff negligently injured the affected bodily member during the course of negligent treatment. The court held that while the plaintiff could not recover for damages resulting from his own negligence, he could recover for damages resulting from defendant's negligence occurring either before or after plaintiff's negligence.[20]

If it is kept in mind that there can be no contributory negligence in the absence of negligence on the part of the defendant,[21] and that "negligence of the patient, to constitute a bar to the suit, must have been an active and efficient contributing cause of the injury; it must have been simultaneous and cooperating with the fault of the defendant, must have entered into the creation of the cause of action, and have been an element in the transaction which constituted it,"[22] it should be obvious that if the requisite elements of primary negligence[23] be made out against a defendant surgeon, then a plaintiff's prior acts cannot constitute contributory negligence.

The largest number of cases in which the issue of the patient's contributory negligence has arisen concerned the patient's failure

18. Hibbard v. Thompson, 109 Mass. 286, 289 *(1872).*
19. 143 Me. 328, 62 A.2d 174 (1948).
20. Josselyn v. Dearborn, 143 Me. 328, ____, 62 A.2d 174, 181, 182 (1948).
21. James, *Contributory Negligence,* 62 YALE L.J. 691, 697 (1953).
22. Rochester v. Katalan, 320 A.2d 704, 707 (Del. 1974).
23. There must be a duty owed to plaintiff, a breach of that duty, the plaintiff must have been damaged, and the damages must have proximately arisen from the breach of that duty. W. PROSSER, *supra* note 3, at 143.

to follow instructions of the physician. *MuCandless v. McWha,*[24] a case in which the patient claimed that he was unable to follow his doctor's orders due to pain, was decided upon principles of primary negligence, the court stating that if the patient will not conform to directions, or under the pressure of pain cannot, "his neglect is his own wrong or misfortune, for which he has no right to hold his physician responsible."[25] The concurring opinion did address the question of contributory negligence, stating first that if the proposed treatment "be painful, injurious and unskillful, he is not bound to peril his health, and perhaps his life, by submission to it."[26] The judge then put the burden of proving the propriety of the refused treatment on the doctor with the further warning that "it will not do to cover his own want of skill by raising a mist out of the refractory disposition of the patient."[27] The opinion then went on to state that the "intemperate habits" of the patient, rather than furnishing an excuse for negligence, was an admonition to the physician that the case called for a greater exercise of skill and care than would be needed for the ordinary case.[28] Another aspect of the contributory negligence defense in the malpractice action is that, as is true generally,[29] the plaintiff's condition is one of the circumstances to be considered in connection with the question of his due care,[30] and that a sick man will not be held to the same standard of conduct as a well man.[31]

The rule on plaintiff's negligence when occurring subsequent to the defendant's negligence was stated in *Sanderson v. Holland*[32] as follows:

> While then it is a good defense, in an action for negligence, that the negligence of the plaintiff (patient), at the time of the injury, contributed to produce the injury, yet it is no answer to an action, that the injured party, subsequent to the injury, was guilty of negligence which aggravated it. The negligence that will constitute a defense must have concurred in producing the injury.[33]

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24. 22 Pa. 261 (1853).
25. McCandless v. McWha, 22 Pa. 261, 268 (1853).
26. *Id.* at 272.
27. *Id.*
28. *Id.*
29. W. PROSSER, *supra* note 3, at 419.
30. Williams v. Marina, 162 A. 796, 799 (Ver. 1932).
31. *Id.*
32. 39 Mo. App. 233 (1889).
33. Sanderson v. Holland, 39 Mo. App. 233, 239, (1889). *See also* Bird v. Pritchard, 33 Ohio App. 2d 31, 291 N. E.2d 769 (1973).

The court held that where the defendant surgeon negligently set plaintiff's arm, subsequent negligence in nursing care chargeable to plaintiff would only mitigate the damages, and not bar recovery.[34]

When the patient failed to properly brush her teeth as instructed by her dentist thereby adding to the damage in *Morse v. Rapkin,*[35] the court held that such action of plaintiff went only to mitigation, stating that "where the gravamen of the action is the improper profesional treatment, the patient's failure to follow instructions does not defeat the action."[36]

If the plaintiff's failure to follow instructions does not result in any injury there is neither contributory negligence nor mitigation. In *Bird v. Pritchard*[37] the plaintiff failed to return for a visit three days after defendant's act, as the patient had been instructed. However, the irreparable injury had already occurred by the third day and it could not be said that plaintiff's acts had contributed to the injury.

Conversely, where plaintiff's acts subsequent to the major act of treatment but simultaneous with defendant's negligent post-operative treatment concurs in the creation of the injury, there is no recovery. Such was the case in *Butler v. Berkeley,*[38] in which plaintiff's negligently removing a tube through which he was fed was a joint factor with defendant's post-operative care causing infection after plastic surgery, the court holding that plaintiff was thereby legally "the sole author of his own misfortunes."[39]

The question has sometimes arisen whether plaintiff's refusal to submit to certain medical procedures has constituted contributory negligence. In *Morris v. Despain,*[40] the defendants had negligently set plaintiff's arm. It was shown that the arm could probably be broken again and correctly set if plaintiff would allow it to be reset, which she refused. The court stated as follows:

> Appellee was not required to submit to have her limb rebroken in order to relieve appellants from liability for lack of ordinary skill and care. Moreover, there was evidence tending to show that such an operation would be

34. 39 Mo. App. at 240.
35. 24 App. Div. 2d 24, 263 N.Y.S.2d 428 (1965).
36. Morse v. Rapkin, 24 App. Div.2d 24, ____, 263 N.Y.S.2d 428, 430 (1965).
37. 33 Ohio App. 2d 31, 291 N.E.2d 769 (1973).
38. 25 N.C. App. 325, 213 S.E.2d 571 (1975).
39. Butler v. Berkeley, 25 N.C. App. 325, ____, 213 S.E.2d 571, 576 (1975).
40. 104 Ill. App. 452 (1902).

> attended with great pain and that at her age and in her physical condition, there was great danger that it would prove fatal to her. The law did not require appellee to risk such danger before she could sustain her suit.[41]

A somewhat different situation was present in *Hunter v. United States.*[42] There the government physicians negligently failed to perform a necessary operation which was consented to. When the decision was made to go ahead and operate, the plaintiff withdrew his consent. The court found this to be contributory negligence. There did not appear to be any good reason for the patient denying or withdrawing his consent to the surgery.

A fact situation similar to that of the *Morris* case was found in *Leadingham v. Hillman.*[43] The rule was set forth as follows:

> It is not, as a matter of law, the duty of the injured person to submit to a serious surgical operation for the purpose of effecting a cure. He is only required to exercise his best judgment in the matter, and to do what a reasonable person would do under the circumstances.[44]

The court then held that plaintiff's failure to have his arm rebroken was at most grounds for mitigating damages, and then only if the jury found that in the exercise of ordinary care he should have submitted to the rebreaking.[45] The same rule was followed in *Dodds v. Stellar,*[46] which held that plaintiff's refusal to undergo a suggested amputation could have been "because of his extended experience, one of justifiable fear of want of their skill."[47]

Summarizing the law of contributory negligence in the medical malpractice action, most courts require plaintiff's negligent act to have occurred simultaneously with and in conjunction with defendant's negligent acts before such will be a bar to recovery. Mere aggravation of the injury caused by defendant is not enough. And, where plaintiff's negligence was first in time, the defendant physician will be held liable for any aggravation of the injury which he negligently causes, and for the injury itself from the date of treament if the doctor's negligence prevents a recovery from

41. Morris v. Despain, 104 Ill. App. 452, 454 (1902).
42. 236 F. Supp. 411 (D.C. Tenn. 1964).
43. 224 Ky. 177, 5 S.W.2d 1044 (1928).
44. Leadingham v. Hillman, 224 Ky. 177, ____, 5 S.W.2d 1044, 1045 (1928).
45. *Id* at ____, 5 S.W.2d at 1046.
46. 77 Cal. App. 2d 411, 175 P.2d 607 (1946).
47. Dodds v. Stellar, 77 Cal. App. 2d 411, ____, 175 P.2d 607, 613 (1946).

the ailment which would have been effected but for the want of the requisite degree of skill and care. In either case, plaintiff can recover only for those damages attributable to defendant's distinct negligence. As with all factual issues, plaintiffs' contributory negligence is a question for the jury unless reasonable minds cannot differ.

II. INFORMED CONSENT

The core of the "doctrine of informed consent" is that a patient, before he can be said to validly consent to medical procedure, must first have been adequately informed of the risks and benefits of, and the alternatives to, the proposed procedure. Beyond that, the courts are in disagreement as to whether the action sounds in negligence or battery, whether the standard imposed upon the physician is one of adherence to good medical practice or to one created wholly by law, the types of risks which must be disclosed and a myriad of other questions.[48]

The foundation of this doctrine is the rule that "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[49] From this basic concept, deeply rooted in the common law,[50] it was an easy extension to create the requirement that in order for a patient's consent to be valid, it must be "informed."

Although the concept of informed consent was created as early as 1918,[51] the new wave of cases began with two cases decided in 1960, *Natanson v. Kline,*[52] and *Mitchell v. Robinson.*[53] Both of these cases were decided upon negligence, although in some states an action based upon lack of informed consent is treated as an action for battery.[54] The vast majority of states do treat the action as one for negligence.[55]

The strongest split in the courts is upon the standard to which the physician shall be held. In the *Natanson* case the court ruled that

48. For a collection of a large number of commentaries upon the various issues, *see* WALTZ & SCHEUNEMAN, *informed consent to therapy,* 64 NW. U.L. REV. 628 n. 1 (1970).

49. Schloendorff v. Society of N. Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

50. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 18 (2d ed. 1955).

51. Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918).

52. 186 Kan. 393, 350 P.2d 1093 (1960), *clarified and rehearing denied,* 187 Kan. 186, 354 P.2d 670 (1960).

53. 334 S.W.2d 11 (Mo. 1960).

54. *See, e.g.,* Scott v. Wilson, 396 S.W.2d 532 (Tex. Civil App. 1965).

55. Comment, *Informed Consent as a Theory of Medical Liability,* 1970 WIS. L. REV. 879, 885 (1970).

the duty of the physician to disclose was "limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances."[56] Although the *Mitchell* case held that expert testimony was not required in an informed consent case,[57] this point was overruled in *Aiken v. Clary*[58] in which the court held that to sustain his burden of proof, the plaintiff must introduce expert testimony of what a reasonable medical practitioner would have disclosed under the same or similar circumstances.[59] This is the majority rule.

The leading case on the other position taken by some courts is *Centerbury v. Spence.*[60] The court's analysis of the problem began with the premise that a person has the basic right to decide what shall be done with his own body.[61] Seeing this as the basis for informed consent, the court had no difficulty in finding that "respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."[62] The test formulated by the court for determining whether a risk should be divulged began with the proposition that "all risks potentially affecting the [patient's] decision must be unmasked."[63] The limitations upon this rule are: (1) that the materiality of the risk is decided upon a reasonable person basis, i.e. whether a reasonable person would deem the risk material; (2) that an emergency patient unable to consent, as for example an unconscious patient, need not be given the information concerning the procedure; and (3) that a risk need not be divulged if there are theraputic reasons for not revealing the risk to the patient.[64] These last two limitations are also applied to the majority rule.[65] This test requires some understanding on the part of the physician, for the over-reacting doctor may find himself in the position of the defendant in *Ferrara v. Galluchio,*[66] in which the court held that there was a duty not to

56. 186 Kan. at ____, 350 P.2d at 1106.
57. 334 S.W.2d at 16.
58. 396 S.W.2d 668 (Mo. 1965).
59. Aiken v. Clary, 396 S.W.2d 668, 675 (Mo. 1965).
60. 464 F.2d 772 (D.C. App. 1972), *rehearing denied,* 409 U.S. 1064 (1972).
61. Canterbury v. Spence, 464 F.2d 772, 780 (D.C. App. 1972), *quoting* Schoendorf v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).
62. 464 F.2d at 784.
63. *Id.* at 787.
64. *Id.* at 787-89. On the last limitation, the court was careful to note that the privilege to withhold information for theraputic reasons must be carefully circumscribed, and that a physician may not withhold information simply because he might feel that its revelation might cause the patient to undergo a procedure which the physician feels is necessary.
65. *See, e.g.,* Roberts v. Woods, 206 F. Supp. 579, 583 (S.D. Ala. 1962); Koury v. Follo, 272 N.C. 366, ____, 158 S.E.2d 548, 555 (1968).
66. 5 N.Y.2d 16, 152 N.E.2d 249, 176 N.Y.S.2d 996 (1958).

unduly alarm a patient with an unnecessary disclosure upon the risks involved.

It should be noted that there are exceptions to the general limitation of both the majority and minority rules which obviate the necessity of making disclosure. For example, if the parents of a minor are available, their consent, with all that must accompany it, is required.[67] And where an adult patient is unable to understand the risks involved and cannot make an informed decision, as when the physical condition itself or the treatment thereof renders a patient incoherent or incapable of understanding or reasoning, then the informed consent of the patient's relatives must be obtained.[68] Informing the patient's relatives and even minister can be required not only to obtain their consent but also for the purpose of enabling them to obtain, by means of their position of trust with the patient, the consent of the patient himself.[69]

Although most of the cases have dealt with nondisclosure of risks, the required revelations include anything which might affect a patient's decision.

> A doctor has the duty to make a reasonable disclosure to his patient of the significant risks in view of the gravity of the patient's condition, the probabilities of success, and any alternative treatment or procedures, if such are reasonably appropriate, so that the patient has the information reasonably necessary to form the basis of an intelligent and informed consent to the proposed treatment or procedure.[70]

Even though a patient may be thoroughly informed of the procedure which he undergoes, the physician may still be liable if a known risk inherent in that procedure, but not in an alternative procedure not known to the patient, becomes a reality and the patient would have chosen the undisclosed procedure over the one actually performed.

The issue of causation has troubled the courts slightly. Obviously, for the patient to recover, it is necessary that he show that, had he been adequately informed of the risks, alternatives, etc., he

67. Bonner v. Moran, 75 D.C. App. 156, 126 F.2d 121 (1941).
68. Morris, *Malpractice: Medical-The Important Events of the Past Two Years*, 30 INS. COUNSEL J. 44, 56 (1963).
69. Steele v. Woods, 327 S.W.2d 187 (Mo. 1959).
70. Cunningham v. Yankton Clinic, 262 N.W.2d 508 (S.D. 1978).

would not have undergone the procedure to which he had consented. As has been pointed out[71] it is asking too much to expect the patient, after he has actually experienced the injury, to be able to truthfully and objectively state whether he would have consented to the procedure had he been properly informed of the risk of just such an injury. The *Canterbury* court ruled that causation is to be established objectively, by use of the reasonable standard. That is, the jury must find that a person could reasonably be expected to not undergo the procedure were he to be informed of the risk.[72] This appears to be contrary to the rule which the court laid down, that the physician must reveal any risk *potentially* affecting the patient's decision, although the court's causation rule is tempered somewhat by allowing the plaintiff to testify concerning whether he would have accepted the proposed treatment.[73] Another court has set forth a considerably more amorphous standard. In *Aiken v. Clary,*[74] the defendant compalined that plaintiff had failed to make a submissible case in that there was no proof that plaintiff would not have consented to the procedure if he had been informed of the risks. The court's reply was as follows:

> Such testimony is not required. . . .Such a requirement would make recovery impossible in the case of a patient who died or, as here, was unable to testify. This does not mean, however, that plaintiff is not required to establish a causal connection between the doctor's failure sufficently to inform and the injury for which recovery is sought. The matter of causation still must be submitted to the jury.[75]

The only requirement then imposed upon the jury was that they must believe that the plaintiff would not have consented had the risks been explained. Perhaps this standard does allow too much emphasis upon plaintiff's post-injury, subjective testimony. Proper cross-examination and closing argument techniques should remedy that problem, however. And it allows for greater consideration of the subjective factors which enter any individual's consideration of what he does and does not wish to have done with his body.

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71. Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 646-48 (1970).
72. 464 F.2d at 791.
73. *Id.*
74. 396 S.W.2d 668 (Mo. 1965).
75. *Id.* at 676.

III. ASSUMPTION OF RISK

Assumption of risk "has been a subject of much controversy, and has been surrounded by much confusion, because 'assumption of risk' has been used by the courts in several different senses, which have been lumped together under the one name, usually without realizing that any differences exist, and certainly with no effort made to make them clear."[76] This confusion has had effect on the law of assumption of risk as it applies to medical malpractice suits.

Prosser divides assumption of risk into three general categories: (1) where the plaintiff has agreed to relieve the defendant of any duty of care to him; (2) where the plaintiff voluntarily enters into some relation with the defendant with knowledge that the defendant will not protect the plaintiff; and (3) where the defendant has already negligently created a risk and the plaintiff voluntarily exposes himself to the risk.[77] A more thorough breakdown, and one which is better suited for analysis of assumption of risk in the field of malpractice, is found in *Meistrich v. Casino Arena Attractions,*[78] and will be used here. The breakdown there was: (1) contractual waiver of liability; (2) consensual waiver, as for example where one participates in a contact sport; and (3) where the injury was neither intended nor contractually made nonactionable. Within the last category, assumption of risk is broken down into its primary meaning, that the defendant either owed no duty or did not breach such duty; and its secondary meaning, that the plaintiff either unreasonably encountered a known (or reasonably discoverable) risk, or unreasonably conducted himself once he reasonably encountered such a risk.[79]

The first category is not important to malpractice law, because any attempt by a physician to contract away his liability for his negligence toward a patient will be declared void as "contrary to the precepts of public policy."[80] The secondary category is covered by the doctrine of informed consent, which has already been discussed. Within the last category, the primary type of assumption of risk centers simply upon whether the defendant was negligent or not and does not concern the plaintiff's acts, except insofar as they may have been the cause of his injuries.

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76. W. PROSSER, *supra* note 3, at 439.
77. *Id.* at 440.
78. 31 N.J. 44, 155 A.2d 90 (1959).
79. Meistrich v. Casino Area Attractions, 31 N. J. 44,—, 155 A.2d 90,93 (1959).
80. Hales v. Raines, 162 Mo. App. 46, 141 S.W. 917, 923 (1911).

This leaves from within the last category, the secondary type of assumption of risk available as a defense to the medical malpractice action. The general statement has been made that a patient never assumes the risk of the negligence of the treating physician,[81] but this rule is not without its exceptions.

In *Champs v. Stone,*[82] the plaintiff went to defendant for a series of injections. On one occasion, the defendant was quite obviously intoxicated. After much coaxing by defendant the plaintiff agreed to let defendant perform the injection, which the defendant proceeded to do in a negligent manner. The court held that plaintiff was guilty of contributory negligence and had assumed the risk of the defendant negligently performing the injection,[83] thereby equating assumption of risk with contributory negligence.

In *Kirschner v. Keller,*[84] plaintiff went to a chiropractor who removed plaintiff from a drug which he had been taking to assist in controlling his epileptic condition. In regards to plaintiff's claim that defendant's withdrawing plaintiff from the drug increased plaintiff's epileptic seizures both in number and intensity, the court held that by his knowingly seeking treatment by a drugless practitioner plaintiff thereby assumed all of the risks attendant with such treatment, the maxim *volenti non fit injuria* being applied.[85]

Such cases appear to be contrary to the principle that the standard of skill to which the practioner will be held is one set by law.[86] In *Nelson v. Harrington,*[87] the plaintiff knowingly secured the services of a clairvoyant physician. To defendant's claim that he should not be held to the standard to which a physician of orthodox medicine is held, the court replied as follows:

> One who holds himself out as a healer of diseases, and accepts employmet as such, must be held to the duty of reasonable skill in the exercise of his vocation. Failing in this, he must be held liable for any damages proximately caused by unskillful treatment of his patient. . . .The theory upon which an expert practices his profession, or trade, the sources from whence he derived his knowledge of it, the tools and appliances he employs in

81. Valdez v. Percy, 35 Cal. 2d 338, 217 P.2d 422 (1950); Los Alamos Medical Center v. Coe, 58 N.M. 686, 275 P.2d 175 (1954).
82. 74 Ohio App. 344, 58 N.E.2d 803 (1944).
83. Champs v. Stone, 74 Ohio App. 344,—,58 N.E.2d 803,803(1944).
84. 70 Ohio App. 111, 42 N.E.2d 463 (1942).
85. Kirschner v. Keller, 70 Ohio App. 111,—,58 N.E.2d 463, 463 (1942). *Accord,* Mainfort v. Giannestras, 67 Ohio Abs. 380, 49 Ohio Op. 440, 111 N.E.2d 692 (1951).
86. Parkell v. Fitzporter, 301 Mo. 217,—,256 S.W.239, 242 (1923).
87. 72 Wis. 591, 40 N.W. 228 (1888).

> the exercise of his calling, his methods of work, are not controlling considerations. . . .The law. . . only takes cognizance of the question, did the practioner or expert render the service he undertook in a reasonable skillful manner?[88]

This is in line with the rule that the foundation of the physician-patient relationship is laid on the theory that the relevant subject matter is one in which the physician is knowledgeable and the patient is ignorant, and that the "ignorant and ailing layman ordinarily relies implicitly on the word of the physician."[89]

Closely related is the situation in which the physician follows the advice of the patient rather than his own. In *Gramm v. Boener,*[90] plaintiff's set arm did not heal in proper alignment and he requested the defendant to rebreak and reset the arm which, although against his better judgment, the defendant did. The court held that the plaintiff had substituted his own judgment for that of his physician, and applied the maxim *volenti non fit injuria.*[91] In light of the fact that a patient's consent to an operation does not relieve a physician from his negligence in deciding upon recommending or performing such an operation,[92] the result in *Gramm* appears to erroneous.[93]

IV. THE RELATIONSHIP BETWEEN THE THREE DOCTRINES AS APPLIED TO ACCEPTING OR REJECTING TREATMENT

Informed consent is concerned with the patient's decision whether to accept or reject treatment, as is assumption of risk when the defense is usually interposed. The defense of contributory negligence occurs in cases dealing with a patient's decision regarding treatment with a frequency second only to cases where the patient negligently failed to follow his physician's instructions. Therefore, the interrelationship of these three legal principles in the situation in which the patient makes a choice as to, or consents to,

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88. Nelson v. Harrington, 72 Wis. 591,—,40 N.W. 228, 233 (1888). *See also* Logan v. Weltmer, 180 Mc. 322, 79 S. W. 653 (1904).

89. Halverson v. Zimmerman, 60 N. D. at 120-21, 232 N.W. at 757.

90. 56 Ind. 497 (1877).

91. Gramm v. Boener, 56 Ind. 497, 502 (1877).

92. Valdez v. Percy, 35 Cal. 2d 338, 217 P.2d 422 (1950).

93. For a similar opinion *see* Smith, *Antecedent Grounds of Liability in the Practice of Surgery,* 14 ROCKY MTN. L. REV. 233, 289 (1942). *See* D. LOUISELL & H. WILLIAMS, 1 MEDICAL MALPRACTICE 243 n.15 (1973) which although discussing the *Gramm* case favorably, does cite the Smith article and then states that

> [W]hen the problem of Gramm v. Boener is analyzed in terms of a physician's duty

treatment is important in many medical malpractice cases. And as stated, the relationship is important even in those jurisdictions which have adopted comparative negligence.[94]

If a plaintiff is provided with insufficient information to knowingly and intelligently consent to a procedure, that patient is unable to assume the risks of that procedure. This is clear as to the assenting type of assumption risk, for a plaintiff will not be held to have assumed the risks of which he had no knowledge.[95] And as regards the secondary type of assumption of risk, there must be some type of acceptance of the risk, whether actual or constructive,[96] before the plaintiff will be denied recovery. In either event the physician's failure to explain the risks will prevent the patient from being in a position where it could be said that he assumed the risks of his consenting to or refusing proffered treatment.[97]

Although no court has yet expressly so held, it is possible to use presently existing legal principles to conclude that an individual cannot be contributorily negligent in a medical malpractice action. It is well established that a plaintiff is not to be required to surrender a valuable right merely because of conduct on the part of the defendant which threatens plaintiff with what would otherwise be an unreasonable risk.[98] If Justice Cardozo's important statement[99] is to be given its full logical effect, it would be impossible for an individual's exercise of his right to determine what shall be done to his body to constitute contributory negligence. Of course, a physician would not be chargeable with negligence in not performing the refused treatment. This would, however, prevent the defendant physician from setting up the plaintiff's acts as the proximate cause of plaintiff's injuries if the defendant is negligent.

It appears, then, that it is possible for the defendant to be held fully liable for the effects of his negligence where the only defense offered is plaintiff's negligently refusing treatment or his assuming the risks of the treatment rendered.

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rather than a patient's assumption of risk, it seems more difficult to accept the proposition that a physician is justified in undertaking a procedure which he believes is not good practice merely because a patient requests it. A patient's wishes may be a relevant factor where medical judgment is doubtful, but for the physician explicitly to violate such judgment only because of the importunities of the patient seems highly questionable.

94. The importance of some of the distinction vanishes where contributory negligence and assumption of risk in its secondary meaning have been combined, or where both are subject to provisions of comparative negligence statutes.

95. Calanchini v. Bliss, 88 F.2d 82 (9th Cir. 1937).

96. Annot., 82 A.L.R.2d 1218 at §§ 4, 5 (1962).

97. This result is suggested in D. LOUISELL & H. WILLIAMS, *supra* note 93, which states "[i]t's [(the defense of assumption of risk)] availability may directly depend upon the physician's diligence and effectiveness in exposing and explaining risks to the patient." *Id.* at 246.

98. W. PROSSER, *supra* note 3 at 425.

99. *Supra* note 49 and text accompanying.