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The Patient's Duty to Co-operate

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Introduction

Since publication of the celebrated dictum of the late Mr. Justice Bissonnette to the effect that "*. . . dès que le patient pénètre dans le cabinet de consultation du médecin, prend naissance entre celui-ci et le malade, par lui-même ou pour lui-même, un contrat de soins professionnels*"[1], there has been a noticeable but nonetheless understandable tendency on the part of contemporary jurists to interpret this *sui generis* contract with a greater emphasis on the obligations of the medical practitioner[2]. Indeed, one would almost conclude that the patient's duty is limited to presenting his or herself at the place of treatment along with a sufficient sum of money or a Quebec Health Insurance card, and passively submit to treatment[3]. In reality, the patient very often has quite an active role in the pursuit of recovery. This participation may take the

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1 *X. v. Mellen ès qual.*, (1957) Q.B. 389, at pages 408-409.

2 For example: According to P.A. CREPEAU, ". . . le contrat médical impose, en général, au médecin quatre obligations: l'obligation de renseigner le malade, l'obligation au secret professionnel, l'obligation de donner des soins, l'obligation de donner des soins compétents, attentifs et consciencieux", *La responsabilité civile médicale et hospitalière: évolution récente du droit québécois*, in *Futura Santé*, 2nd ed., Montreal, Intermonde, 1968, p. 7. As CREPEAU quite properly points out, since there are no special rules governing the content of this type of contract, one must have recourse to article 1024 C.C., a fundamental rule in the interpretation of conventions: "The obligations of a contract extend not only to what is expressed in it, but also to all the consequences which, by equity, usage or law, are incident to the contract, according to its nature". Cf. *La responsabilité médicale et hospitalière dans la jurisprudence québécoise récente*, (1960) 20 R. du B. 433 at p. 453; *Les transformations de l'établissement hospitalier et les conséquences sur le droit de la responsabilité*, in *Le droit dans la vie economico-sociale*, Livre du Centenaire du Code civil, vol. 2, Montréal, P.U.M., 1970, p. 199. For a more complete examination of medical liability in Quebec one may consult, by the same author, *La responsabilité civile du médecin et de l'établissement hospitalier*, Montréal, Wilson & Lafleur, 1956.

3 According to CREPEAU in *La responsabilité civile du médecin et de l'établissement hospitalier*, *ibid.*, p. 69: "Les relations entre les médecins ou chirurgiens et leurs malades sont, en effet, dans la plupart des cas, régies par une convention — au moins tacite — génératrice d'obligations juridiques réciproques: le malade s'engage à payer les honoraires requis; le médecin, à donner des traitements et soins prudents et diligents. L'inexécution ou l'exécution défectueuse de ces obligations par l'une ou l'autre des parties donne lieu à l'exercice de l'action contractuelle en dommages-intérêts fondée sur les articles 1065, 1071 et suivants du Code civil de Québec". See also CREPEAU in (1960) R. du B., *ibid.*, p. 454 and in *Futura Santé*, *ibid.*, p. 7.

form either of a positive act or an abstention; for example, a patient might be required to perform prescribed forms of therapy for improvement of a crippled limb, or he may be ordered to give up alcohol and tobacco in order to cease irritating an ulcer. In any case the degree of co-operation by the patient may have a direct bearing on the outcome of treatment.

However, medical practitioners are quick to point out that patients often fail to follow orders for several different reasons which may include forgetfulness, overconfidence in their state of recovery, fear, discomfort, immaturity, mental or intellectual incapacity, financial inability to assume certain expenses, and finally, just plain cussedness. Fortunately in the majority of cases, the diseases or afflictions involved clear up, due to their self-limiting nature and the innate healing capacity of the human body. Nevertheless, for the less fortunate minority the consequences are disastrous.

This brings us to the crux of a problem involving medical liability: If, as is readily admitted, we are dealing with a synallagmatic contract[4], must the medical practitioner take his patient as he finds him and assume the additional potential risk due to a possible lack of co-operation on the part of the latter; or can he be totally or partially exonerated from fault because of said lack of co-operation? In other words, and more simply stated, does the duty of the patient to co-operate form part of the *contrat de soins*? If so, what is its extent, and what is the sanction of this obligation?

1) DOES THE DUTY TO CO-OPERATE EXIST?

The recent addition to the Civil Code stipulating that "the human person is inviolable"[5], may be considered as the formal consecretion by the Quebec legislator, of a rule of doctrine and jurisprudence long recognized in many jurisdictions[6]. This principle was succinctly enunciated by Justice Cardozo in *Schloendorff v. Society of New York Hospital* in the following terms:

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" [7].

Carbonnier later resumed French doctrine somewhat along the same lines when he wrote:

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4 *Ibid.*, René SAVATIER, Jean SAVATIER, Jean-Marie AUBY, Henri PEQUIGNOT, *Traité de droit médical,* Paris, Librairies Techniques, 1956, pp. 211-212, no. 237; p. 269, no. 296.

5 Art. 19 C.C. This article continues as follows: "No one may cause harm to the person of another without his consent or without being authorized by law to do so".

6 E.g. Quebec, the Anglo-Canadian provinces, the United States, England, France, Belgium, *inter alia.*

7 (1914) 105 N E 92 (N.Y.) at p. 93.

> "Au vrai parler de 'propriété de son propre corps', de 'droit à l'intégrité corporelle' d' 'inviolabilité de la personne humaine', ce n'est que traduire sous des formes différentes, toujours inadéquates par quelque côté, un *noli me tangere* fondamental, une liberté physique élémentaire qui est un des axiomes inexprimés de notre système juridique individualiste. . ." [8]

The principle of inviolability of the human body involves two distinct elements, the first of which includes the notion of *noli me tangere,* or prohibition to affect against one's will, a person's physical integrity in any degree or manner[9]. In the realm of medical law, this would be interpreted as an interdiction for the practitioner, to perform any treatment without prior enlightened consent from the patient or his authorized representatives[10]. The second element is the right to self-determination, which consists essentially of the freedom for a person to act and live according to his or her social, philosophical and religious ideals[11]. In certain circumstances, this right would appear to extend to self-destruction[12]. According to Justice Owen:

> "People are killing themselves at various rates by excesses in eating, consumption of alcohol, use of tobacco, use of drugs, by violent acts of immediate self-destruction, and in other ways. From a legal point of view, as distinct from a religious point of view, it may be asked whether any person has the legal obligation, or even the right to prevent another person from shortening or terminating his own life" [13]

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8 This affirmation is contained in a note to a judgment of Lille, 18 mars 1947; D.1947.507, at page 509.

9 R. DIERKENS, *Les droits sur le corps et le cadavre de l'homme,* Paris, Masson & Cie., 1966, p. 44, no. 52.

10 L. KORNPROBST, *Responsabilités du médecin devant la loi et la jurisprudence françaises,* Paris, Flammarion, 1957, p. 237; SAVATIER, SAVATIER, AUBY, PEQUIGNOT, *op. cit.,* p. 223, no. 247; R. SAVATIER in *Juris-Classeur de la responsabilité civile et des assurances,* Paris, Editions Techniques S.A., 1970, vol. 4, xxxa, p. 18, no. 126; W.C.J. MEREDITH, *Malpractice Liability of Doctors and Hospitals,* Toronto, Carswell Co. Ltd., 1956, p. 154; CREPEAU, *loc. cit.,* (1960) 20 R. du B., 433 at page 455; R. NERSON, *L'influence de la biologie et de la médecine modernes sur le droit civil,* 33 Etudes de Droit contemporain, Nouvelle série, 67, at page 78; *Parmley and Parmley and Yule,* (1945) S.C.R. 635 at pages 645-646; *Dame Dufresne v. X.,* (1961) S.C. 119 at page 128; *Beausoleil v. La Communauté des Soeurs de la Charité de la Providence et al,* (1965) Q.B. 37 at page 41; Lille 18 mars 1947, D.1947.507 (Note CARBONNIER); *Schloendorff v. Society of New York Hospital,* (1914) 105 N E 92.

11 DIERKENS, *op. cit.,* p. 42, no. 49.

12 *Ibid.*

13 *Hôpital Notre-Dame v. Dame Villemure,* (1970) C.A. 538 at p. 552. A critique of this judgment is contained in A. POPOVICI's article, *La responsabilité médicale et hospitalière lors du suicide d'un malade mental,* (1970) 30 R. du B. 490. Happily, the Supreme Court has subsequently (June 29th, 1972) reversed the Court of Appeal and has retained the dissent of Choquette J. The Supreme Court abstained however from commenting on the above quoted affirmation of Owen J.

Nevertheless, it should be brought out at this point that man's right to corporeal integrity is far from absolute since the requirements of society as a whole may predominate, especially in areas of public health and the prevention and control of epidemics[14]. Consequently, in the case of venereal[15] or certain other contagious diseases[16], or in matters of mental health[17] where public order is involved, treatment may be forced upon the patient without any regard to informed consent[18]. However, in any given situation, unless legislation expressly permits the imperatives of society to override the objections of each individual, the right to personal integrity must be reaffirmed[19]. If, therefore, under ordinary circumstances, the individual is free to enter into or withdraw from the *contrat de soins* at any moment that his fancy may dictate, this would imply that as long as he wishes treatment to be maintained, the patient must co-operate with the medical practitioner[20]. Thus, it may be stated that as a rule, the patient has a duty to co-operate with the practitioner to the extent of the former's capacity[21].

Of course, there are numerous situations in which the capability of the patient to co-operate will be diminished, thus reflecting on his liability and that of the physician: The first which comes to mind involves the child. Naturally, one cannot give as a hard and fast rule that all children are released from the duty to co-operate since in each case, one would be dealing with a question of

14 DIERKENS, *op. cit.*, p. 119, no. 182.

15 *Public Health Protection Act* (Bill 30), assented to the 21st of December 1972, arts. 10, 12.

16 *Ibid.*

17 *Mental Patients Institutions Act,* R.S.Q. 1964, ch. 166, art. 12. This law will be replaced by the *Mental Health Act* (Bill 8, 29th Legislature, 3rd session, first reading).

18 Certain difficulties may be encountered when the requirements of law or regulation come into conflict with religious beliefs. Cf. G. HOW, *Religion, Medicine and Law*, (1960) 3 C.B.J. 365; *Holcomb v. Armstrong,* (1952) 239 P 2d 545 (dealing with the refusal of a Christian Scientist to submit to the chest x-ray required for admission to university); *Commonwealth v. Jacobson,* (1905) 197 U.S. 11 (compulsory vaccination in order to attend school). For additional information on the subject one may consult W. CURRAN, E. SHAPIRO, *Law, Medicine and Forensic Science.*

19 For example, one cannot by means of a search warrant, operate on an accused bank robber against his will in order to extract a policeman's bullet: Cf *Laporte v. Laganière J.S.P. et al.,* (1972) 18 C.R.N.S.357, at pp 368, 369. (Hugessen, J.)

20 Indeed, in certain cases, a lack of co-operation could be construed as a withdrawal of consent and the erection of the *noli me tangere* barrier to the treatment in progress. E.g. *Beausoleil v. La Communauté des Soeurs de la Charité de la Providence,* (1965) Q.B. 37. In most circumstances nevertheless, the lack of co-operation by the patient would not necessarily mean that consent was withdrawn, vide R. SAVATIER, in *Juris-Classeur, op. cit.*, p. 18, no. 128.

21 *Lucas v. Hambrecht,* (1954) 117 N E (2d) 306 (Ill.); see also R. SAVATIER's note to the *arrêt* Cass. Crim. 3 juillet 1969; J.C.P. 1970.11.16447; SAVATIER, SAVATIER, AUBY, PEQUIGNOT, *op. cit.*, p. 269, no. 296.

fact. For example, on the one hand, a child of two with a lacerated eye-lid will not be faulted for being agitated during the suturing[22]; nor will the behavior of a five and a half year old child receiving two vaccinations be subject to legal reproach, when a sudden movement on his part causes a needle to break in his arm[23]. On the other hand, a minor of fifteen who is uncooperative during ordinary treatment will likely be barred from invoking his youthfulness, since it is reasonable to assume that a person of his age has sufficient discernment in order to comprehend the necessity of collaboration. Likewise, the practitioner will be depending on his docility as opposed to that of a much younger person who is more likely to make a fuss.

By the same token the patient suffering from diminished capacity due to insanity[24], senility[25], or heavy sedation[26], will also be held to a less stringent standard[27] as regards the degree of co-operation with the practitioner. In the United States, it has been suggested that due to pain and the gravity of the illness a patient may be less inclined to co-operate than would be a person in relatively better health[28]. This also, therefore, could reflect on the patient's obligations in the *contrat de soins*.

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22 *Wheatley v. Heideman.* (1960) 102 N W (2d) 343 (Iowa).

23 *Cardin v. Cité de Montréal,* (1961) S.C.R. 655, especially at page 659.

24 For example, suicide is the ultimate form of non-cooperation. Cf. Lyon, 7 jan. 1952; D.1952.97; *Hôpital Notre-Dame v. Villemure,* (1970) C.A. 538. (In this case the Court of Appeal did not retain the fault of the hospital. As previously mentioned, the Supreme Court of Canada subsequently reversed the Court of Appeal and held the physician and the hospital liable). Concerning the standard of care required of psychiatric clinics, see MALHERBE, *op. cit.,* p. 105 *et seq.,* and Marseille 29 nov. 1955; J.C.P. 1956.11.9050. Along different lines, there is the interesting case of *Bennett v. State of New York,* (1969) 299 N.Y.S. (2d) 288 involving a mental patient who verbally abused his attendant, and who received a fractured jaw for his efforts. The Court found that the rantings of a lunatic did not constitute provocation and thus would not avail in mitigation of damages.

25 In *Clark v. Piedmont Hospital Inc.,* (1968) S E (2d) 468 (Georgia) a woman 75 years old suffering from bilateral pneumonia and vertigo who was told not to leave bed except to go to the bathroom fell on a vaporizer near her bed and burned herself. The Court found that the hospital had a duty to protect the patient from any known or reasonably apprehended danger due to her mental capacity.

26 *Welker v. Scripps Clinic and Research Foundation,* (1961) 16 Cal. Reptr. 538. In this case, the Court admitted the principle of a defence based on heavy sedation but in the present circumstances felt that the patient was sufficiently lucid to obey instructions.

27 Or none at all in the case of an unconscious patient due to anesthesia (*Page et al v. Brodoff,* (1961) 169 A (2d) 901 (Connecticut), or delirium (*Duke Sanatorium et al v. Hearn,* (1932) 13 P. (2d) 183 (Oklahoma); *Bess Ambulance Inc. v. Boll et al,* (1968) 208 So. (2d) 308 (Florida).

28 D. LOUISELL, H. WILLIAMS, *Medical Malpractice,* New York, Matthew Bender, 1970, vol. 1, p. 249, no. 9:02; *Williams v. Marini,* (1932) 162 A 796 (Vermont), Powers J., (at p. 799): "This plaintiff's condition at the time in question was one of the circumstances to be considered in connection with the question of his due care. It is quite apparent that one in the condition in which he was (according to the evidence) could not be held to the same conduct as a well man".

Another situation, often overlooked due to the fact that it involves a sane capable adult, is that in which a physician or nurse delegates some specialized duties to the patient himself; which duties hindsight indicates as being beyond the capability of the patient to control or comprehend due to a lack of knowledge or insufficient intellectual capacity. For instance, in the British Columbia case of *Marshall v. Rogers*[29], the Court of Appeal found the attending physician negligent and the diabetic patient blameless when the latter drastically reduced his intake of insulin on doctor's orders after having been placed on a special diet. In the words of Justice Fisher:

> "There might be cases in which certain duties might be properly delegated by an attending physician to others... but in a case such as this, where admittedly a dangerous remedy was being tried, it would seem to me that the appellant was negligent in delegating to the patient himself the duty of deciding what his real condition was from time to time from what might be called only his subjective symptons without having daily tests made"[30].

An additional point one should put forward is that when dealing with a patient of diminished capacity (other than an infant or an insane person), who for any reason refuses certain forms of treatment, the medical practitioner would be well advised to:

> ". . . communicate with and advise the (consort) or other members of the family who are available and competent to advise with or speak for the patient or take other steps to bring understanding of the need, home to the plaintiff"[31].

In summary, each factual situation tending to show inability on the part of the patient to co-operate will have to be decided in light of the circumstances and without recourse to a rigid set of rules. Nevertheless, it would be quite safe to say that the burden of proving said incapacity will rest upon the patient[32].

2) WHAT IS THE DUTY TO CO-OPERATE?

The duty to co-operate may be defined as the obligation which weighs upon the patient contracting with a medical practitioner; (a) to disclose all symptons and other pertinent information, (b) to submit to recognized treatment with docility, (c) to follow instructions during the period of treatment and recovery, and finally (d) to return for further treatment as required. Each element of the definition bears closer examination:

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29 (1943) 2 W.W.R. 545.

30 *Ibid.*, at page 555.

31 Per Justice Ruark S.J., in *Steele v. Woods*, (1959) 327 S W (2d) 187 at page 198 (Missouri).

32 When dealing with infants or insane persons, there will be a strong presumption of fact regarding their incapacity (articles 1238, 1242 C.C.).

(a) The duty of honest disclosure[33]

There are three general categories of information which the patient must reveal to the treating practitioner: Firstly he must give personal data such as name, address, telephone number and/or other details permitting accurate identification of the patient. Aside from avoiding confusion in the files, it would also enable subsequent communication with the patient if events should so dictate, as in the recent case of *Ray v. Wagner*[34], in which the plaintiff submitted to a Pap smear administered by defendant. The results of the test revealed cancer but when the physician attempted to contact her, it was discovered that the information given concerning her employment, her address and telephone number was inaccurate. Consequently, plaintiff remained ignorant of her condition for a substantial length of time, thus diminishing her chances of recovery. The Court found that the giving of misleading information could support a finding of contributory negligence[35].

Secondly, the patient must give prior personal history and background which may have a bearing on the treatment sought[36]. Thus the father of a two and a half-year-old girl suffering from vomiting should have told the hospital authorities that his child was discovered that morning with an open aspirin bottle[37]. Likewise, a woman complaining of a sore throat could not reproach the doctor for an error in diagnosis when she failed to tell him that she had been already diagnosed as syphilitic[38]. On another occasion it was also decided that the failure of the husband to warn a psychiatric clinic of his wife's prior history of attempted suicide could operate in mitigation of damages when a lack of close surveillance enabled said wife to hang herself with a corset lace[39].

Thirdly, the patient must describe all pains, infirmities and symptoms from which he is suffering in order to give the physician a clear picture of the illness, and to ensure accurate diagnosis[40].

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33 Edson L. HAINES, *Courts and Doctors,* (1952) 30 C.B.R. 483 at page 486.

34 (1970) 176 N W (2d) 101 (Minn.).

35 *Ibid.,* Otis J., at p. 104. Likewise, in the case of *Somma v. U.S.,* (1960) 180 F Supp 519 (U.S.D.C. East Div. Penn.), *inter alia,* the failure on the part of a civilian employee of the Navy, submitting to a chest x-ray for tuberculosis, to give the name of his personal physician to the government for future reference.

36 LOUISELL, WILLIAMS, *op. cit.,* p. 44, no. 2.13; SAVATIER, SAVATIER, AUBY, PEQUIGNOT, *op. cit.,* p. 270, no. 297.

37 *Johnson v. St. Paul Mercury Insurance Co. et al,* (1969) 219 S (2d) 524 (La.).

38 Paris, 15 oct. 1927; J.C.P. 1927.1401.

39 Lyon, 7 jan. 1952; D.1952.97.

40 SAVATIER in *Juris-Classeur, loc. cit.,* p. 18, no. 128. In *King v. Solomon,* (1948) 31 N E (2d) 838 (Mass.), a patient receiving morphine for pain began ". . . to get a little sneaky. . ." about her condition in order to receive additional drugs. When she became addicted, the question of her contributory negligence was raised.

One must always bear in mind that since the medical practitioner is most often dealing with laymen, a thorough discussion with the patient will normally be required to extract the pertinent information. In most cases the physician would be well advised to ask direct questions covering those areas which interest him professionally since he is generally better qualified to know what is needed[41]. Consequently, except in cases of deliberate lying or reticences, the patient cannot be held liable for withholding information unless it is of such manifest importance that a reasonable person would know enough to declare it spontaneously[42]. Nonetheless, one is strongly led to believe that in the latter hypothesis, the burden of proving what a reasonable person should volunteer would rest upon the practitioner.

(b) The duty to co-operate during actual treatment

Of the two aspects of this particular duty, the first includes the necessity for the patient to remain docile during therapy or treatment. Docility however, must not be confused with apathy since in many cases, the patient will be required to participate in the activities of the medical staff. The most likely examples would be child-birth, and certain types of brain surgery during which the patient is conscious in order to perform certain exercises and to report different sensations while the operation is in progress.

Aside from the actions of patients imposed by the nature of the treatment "it would be obviously unfair to require a [practitioner] to perform his work regardless of the conduct of the patient relating to that performance"[43]. This would be most commonly encountered in relation to the practice of dentistry, where a sudden movement of the head or tongue could cause injury from high-speed air-drills and other instruments[44]. The criterion for establishing whether the patient is responsible for the damages incurred depends upon whether his gesture was a "*mouvement prévisible*" or not[45]. Thus, it would be foreseeable to a dentist that a nervous patient would swallow involuntarily from time to time[46]. In other words, a purely reflex reaction would not be considered a fault on the part of the patient since he would have no control over it and since the competent medical practitioner would expect this to occur occasionally and provide counter-measures.

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41 Dr. Alexander Gibson in HAINES, *loc. cit.*, pp. 499-500.

42 Lyon 7 jan. 1952; D.1952.97; Paris, 15 oct. 1927; J.C.P. 1927.1401.

43 W.W. HOWARD, A.L. PARKS, *Carnahan's The Dentist and the Law,* 2nd ed., St. Louis, C.V. Mosby Co., 1965, p. 84.

44 L. KORNPROBST, *Responsabilités du médecin devant la loi et la jurisprudence françaises,* Paris, Flammarion, 1957, p. 877.

45 Cass.civ. 14 mars 1967; G.P. 1967.2.107.

46 KORNPROBST, *op. cit.,* note 608. On the other hand, it is not foreseeable for a dental patient to get out of the chair during treatment and falling. Cf. Cass.civ. 18 déc. 1956; D.1957.231.

The second aspect of the duty to collaborate during treatment involves allowing the utilization of all recognized medical means at a practitioner's disposal which would facilitate an improvement or cure. Consequently, when a patient refuses to submit to an x-ray[47], to a paravertebral block[47a], to an incision biopsy[48], to orthopaedic surgery[49], or to anesthesia and the help of a second physician[50], he cannot cause the less than satisfactory results to rest solely upon his physician's shoulders. Any person undertaking the care of others must be allowed to employ all available techniques, instruments and procedures; the practitioner acting without said aids would in fact be labouring under a handicap, thus rendering a satisfactory result more difficult to attain. It should be noted that refusal, whether based on economic, psychological, religious or any other grounds will always have a similar legal effect; in most cases the burden of proving that the refusal to submit to certain types of treatment caused non-execution of the *contrat de soins* will rest upon the practitioner.

(c) The duty of following instructions

The recovery stage is probably the most crucial period in the whole process of treatment and yet many patients may tend to overlook the instructions of their physician, since, according to Haines, "all of us have a tendency to forget our doctors as soon as we think we are well"[51]. Nevertheless, the number of cases involving this facet of the duty of collaboration would certainly bear out the fact that disobedience to orders can have serious repercussions on the respective liabilities of the parties.

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47 *Carey v. Mercer,* (1921) 132 N E 353 (Mass.). In Cass.civ. 7 nov. 1961; G.P. 1962.1. 219 dealing with the refusal of a patient with a piece of metal in his eye to submit to an x-ray, the court found the physician liable because: ". . . il appartenait au médecin convaincu de la nécessité d'un tel examen, d'exiger une constatation écrite de l'attitude du blessé et de refuser dans de telles conditions de renfermer et de suturer une plaie 'pénétrante' qui pouvait encore contenir l'éclat de métal. . .".

47a *Steele v. Woods,* (1959) 327 S W (2d) 187 (Mo.).

48 *Hunter v. U.S.,* (1964) 236 F Supp 411 (U.S.D.C. Tenn.).

49 *Peterson v. Branton,* (1917) 162 N W 895. However, the refusal of a patient to have his arm rebroken a second time after the first attempt healed crooked was not held to constitute contributory negligence. Cf. *Parr v. Young,* (1926) 246 P.181 (Kansas).

50 *Summers v. Tarpley,* (1919) 208 S W 266 (Mo.). Nevertheless, when in the presence of "gross intoxication" of the physician, the patient must not submit to treatment, cf. *Champs v. Stone,* (1944) 58 N E (2d) 803 (Ohio).

51 HAINES, *loc. cit.*, p. 486.

The failure to abide by the advice of the physician may take many forms including refusal to restrict activity and remain quiet[52], failure to leave a fractured limb immobilized[53], failure to exercise[54], refusal to remain in hospital for a sufficient period of time[55], and omitting to follow orders pertaining to home-care[56].

Naturally the initiative in informing the patient must reside with the physician because to expect said patient to interrogate his doctor as to what was permitted "would be to require the patient to affirmatively determine whether or not the [practitioner knew] what he [was] doing, which is patently absurd"[57]. There would also be a comprehensible tendency on the part of patients to disregard as unimportant, those things which the physician did not mention[58]. Nevertheless, in Quebec, the onus of proving that instructions were not given will rest upon the plaintiff-patient since, according to Lafleur, J.:

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52 *Welker v. Scripps Clinic and Research Foundation,* (1961) 16 Cal. Rptr. 538 (getting out of hospital bed); *Puffinberger v. Day,* (1962) 24 Cal. Rptr. 533 (allowing sick child to play outside and get wet); *Ault et uxor v. Ross General Hospital,* (1951) 232 P (2d) 528 (Cal.) (getting out of hospital bed); *General Hospital of Greater Miami Inc. v. Gaber,* (1964) 160 So. (2d) 749 (surgical patient told to use bed-pan, is later found eviscerated on the commode); *Carson v. City of Beloit,* (1966) 145 N W (2d) 112 (Wisc.) (failure to stay in bed); *Drummond v. Hodges,* (1967) 417 S W (2d) 740 (Texas) (two days after hemorrhoidectomy patient drives 100 miles instead of staying in bed). However in *Jefferson Hospital Inc. v. Van Lear,* (1947) S E (2d) 441 (Va.), a 75 year-old patient with cataracts was told to call a nurse if he required a bowel movement. After ringing for a half an hour without success, he got out of bed and fell. In this case the court held that the patient's violation of instructions was excusable since "his act was a 'normal response to the stimulus' of the situation created by the hospital's negligent conduct" (Eggleston J., at page 444).

53 *Young v. Mason,* (1893) 35 N E 521 (Ind.) (not keeping arm in sling); *McLendon v. Daniel,* (1927) 141 S E 77 (Ga.) (removing leg from "fracture box" and walking on it); *Stacy v. Williams,* (1934) 69 S W (2d) 697 (Ky.) (prying at cast with a knife stoken from meal-tray etc.); *Shirey v. Schlemmer,* (1967) 223 N E (2d) 759 (Ind.) (using fractured arm to do lifting).

54 *Flynn v. Stearns,* (1958) 145 Atl. (2d) 33 (N.J.).

55 *Feltman v. Dunn,* (1927) 217 N W 198 (S.D.); *Muckleroy et al v. McHenny,* (1932) 16 P (2d) 123 (Okl.); *Brown et al v. Dark,* (1938) 119 S W (2d) 529 (Ark.); *Musachia v. Rosman,* (1966) 190 So. (2d) 47 Fla.). (In the latter case, the patient who was on a diet of strained baby food, also consumed liquor. He died of fecal peritonitis).

56 *Cyr v. Landry,* (1915) 95 A 883 (Me.). (While caring for child, mother disturbs drain tube in pleural cavity thus causing it to fall into said cavity); *Chubb v. Holmes,* (1930) 150 A 516 (Conn.) (failure of dental patient with injured tongue to use particular mouth-wash); *Ernst v. Schwartz,* (1969) 445 S W (2d) 377 (Mo.) (patient fails to wash eye in saline solution after a temporal craneotomy, performed to relieve *tic douloureux,* caused a temporary insensitivity of said eye).

57 HOWARD, PARKS, *op. cit.,* p. 85; *Town v. Archer,* (1902) 4 O.L.R. 383.

58 LOUISELL, WILLIAMS, *op. cit.,* p. 45, no. 2.13; *Wilson v. Corbin,* (1950) 41 N W (2d) 702 (Iowa) at p. 708 (Garfield J.); *Johnson v. U.S.,* (1967) 271 F. Supp 205 (U.S.D.C. Ark.).

"Une jurisprudence uniforme et constante nous enseigne que, dans la Province de Québec, le médecin, dans l'exercice de sa profession, n'assume jamais l'obligation d'assurer la guérison du malade ou de l'accidenté. La responsabilité contractuelle ou délictuelle qui, parfois, peut résulter des soins administrés ou de l'opération effectuée oblige celui qui s'en prévaut à prouver que le médecin ne lui a pas donné des soins consciencieux, attentifs et conformes aux données acquises de la science"[59].

In other terms, in order to succeed, the patient would have to establish that by not furnishing proper advice and instructions, the physician failed to fulfill the terms of the medical contract which require that he give attentive, competent and conscientious care[60].

(d) The duty of returning for further treatment

According to certain authors, the failure to return for further treatment is probably the most common of all failures on the part of patients to co-operate[61]. In this day and age of health insurance, this is likely due to a feeling of optimism and confidence which usually accompanies alleviation of signs and symptoms[62]. No matter what the underlying causes, the courts have had several occasions to examine situations involving a breach of this duty to return. For example, the patients were found responsible for their own injuries in cases dealing with *inter alia,* failure to return after the pain, diagnosed as a shoulder sprain did not diminish[63]; failure on the part of a nervous pregnant woman whose root remained embedded in her jaw following tooth extraction, to return the next day to the dentist[64]; omission by an injured patient to have a prescription for tetanus antitoxin filled and then return for the injection[65]; waiting for two months after treatment for particles of cement in the eye, before complaining that all the matter had not been removed[66]; and finally, failure to return for a second gonorrhea test after the first produced inconclusive results[67].

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59 *Gendron v. Dupré,* (1964) S.C. 617 at page 620; A. MAYRAND, *Permis d'opérer et clause d'exonération,* (1953) 31 C.B.R. 150, at page 156; CREPEAU, *La responsabilité médicale et hospitalière dans la jurisprudence québécoise récente, loc. cit.,* at pages 475 *et seq.; X. v. Mellen,* (1957) Q.B. 389 at page 413; *Dame Cimon v. Carbotte,* (1971) S.C. 622 at pages 628 *et seq.*

60 Cass. civ. 20 mai 1936; D. 1936.1.88 note E.P., SAVATIER, SAVATIER, AUBY, PEQUIGNOT, *op. cit.,* p. 262, no. 286.

61 HOWARD, PARKS, *op. cit.,* at p. 85.

62 LOUISELL, WILLIAMS, *op. cit.,* p. 58, no. 2.21.

63 *Moore and Moore v. Large,* (1932) 46 B.C.R. 179 (Court of Appeal).

64 *Gentile v. De Virgilis,* (1927) 138 A 540 (Penn.).

65 *Gerber et al v. Day,* (1931) 6 P (2d) 535 (Cal.).

66 *Hanley v. Spencer,* (1941) 115 P (2d) 399 (Colo.).

67 *Reis v. Reinard,* (1941) 117 P (2d) 386 (Cal.).

The recent Quebec case of *Cimon v. Carbotte*[68] is a reaffirmation of this particular aspect of the duty to co-operate. The female plaintiff, complaining of a lump in one breast, submitted to an examination by defendant. Her physician was of the opinion that it was a breast dysplasia according to the symptoms manifested at that time. As a result, a biopsy was contraindicated. Dr. Carbotte taught plaintiff how to palpate her breasts and instructed her to return if a change in the lump occurred. About a year later, while being examined by another doctor for an unrelated illness, said second physician noticed the size of the lump which had increased in mass. Subsequent tests revealed a malignancy and the breast was removed. The court found for defendant since, in the terms of Justice Ouimet *inter alia:*

> "La preuve ne permet pas au tribunal d'en arriver à la certitude de l'existence d'une faute de la part du défendeur. Il n'était ni le tuteur ni le curateur de la demanderesse et n'avait certes pas envers elle l'obligation de la rappeler pour consultation ultérieure après lui avoir dit de revenir. Femme de tête et d'initiative, elle se devait de surveiller elle-même l'état de son sein, et, une fois la douleur apaisée, de renouveler ses palpations pour ensuite communiquer le résultat de ses observations au défendeur"[69].

Consequently, the careful medical practitioner would be well advised to give his patient detailed and explicit instructions "as why and when he should be seen again, and what to do if certain enumerated circumstances change"[70]. Indeed many authors go so far as to counsel physicians to notify recalcitrant patients of their medical status and recommend that they continue treatment[71]. Whether this is administratively possible or not is for each physician to decide, but one certainly cannot impugn the value of this procedure as a good defence to an action based on abandonment[72].

As a final point, it would appear that in most jurisdictions, the patient may refuse to return to a physician whose professional skill appears to be below the standard of the members of his profession, without being reproached for a lack of co-operation, provided that competent care is sought immediately[73].

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68 (1971) S.C. 622.

69 *Ibid.*, p. 630.

70 LOUISELL, WILLIAMS, *op. cit.*, p. 58, no. 2.21.

71 HAINES, *loc. cit.*, at page 486; C.J. STETLER, A.R. MORITZ, *Doctor and Patient and the Law,* 4th ed., St. Louis, C.V. Mosby Co., 1962, pp. 123-124; MEREDITH, *op. cit.*, p. 9.

72 STETLER, MORITZ, *ibid.;* B. SHORTEL, M. PLANT, *The Law of Medical Practice,* Springfield, Ill., Charles C. Thomas, 1959, p. 6.

73 *Mlle Bordier v. S.,* (1934) 72 C.S. 316 at page 320; Dijon, 24 jan. 1952; D.1952.171; *Williams v. Wurdemann,* (1912) 128 A 639 (Wash.).

If said subsequent care is not obtained, a malpractice action will still lie against the physician but in certain circumstances, the *quantum* could be reduced[74].

3) SANCTIONS OF THE DUTY TO COLLABORATE

The patient who refuses to co-operate may be exposed to three possible sanctions including (a) total responsibility for all damages suffered; (b) partial liability notwithstanding fault on the part of the physician, and (c) release of the physician from the *contrat de soins*.

(a) Total liability on the part of the patient

There are two situations in which the patient will bear the full burden of his injuries without legal relief. Naturally, the first would be when said patient has nobody to blame for his circumstances but himself[75]. The second situation is encountered in those common law jurisdictions which still admit the defence of contributory negligence.

> "Contributory negligence is conduct on the part of the plaintiff, contributing as a legal cause to the harm he has suffered, which falls below the standard to which he is required to conform for his own protection" [76].

Thus if negligence on the part of the patient occurs contemporaneously with the negligence of the medical practitioner, then said patient will be completely precluded from any recovery[77]. Much more commonly encountered, how-

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74 For example, when the patient fails to seek medical aid and his condition further deteriorates through neglect. Carl E. WASMUTH, *Law for the Physician*, Philadelphia, Lea and Febiger, 1966, p. 161; *George v. Shannon*, (1914) 142 P 967 (Kansas).

75 E.g. *Cité de Verdun v. Mlle Thibault*, (1939) 68 K.B. 1, at page 6 (failure to have a fracture, diagnosed as sprain by a nurse, treated until a month later); *Dittert v. Fischer*, (1934) 36 P (2d) 592 (Ore.) (falling asleep under a heating apparatus); see also cases cited under sections 2(b) and 2(c) *supra*.

76 Restatement of Torts no. 463 cited in W.L. PROSSER, *Handbook of the Law of Torts*, 3rd ed., St. Paul, Minn., West Publishing Co., 1964, p. 427, no. 64.

77 A.R. HOLDER, *Contributory Negligence*, (1971) 218 Journal of the American Medical Association, 785; *Young v. Mason*, (1893) 35 N E 521 (Ind.) Davis, J., (at p. 522): "If the injuries were the result of mutual and concurring negligence of the parties, no action to recover damages therefore lies. A person cannot recover from another for consequences attributable to his own wrong. Nor is it necessary that the negligence of each party be equal to defeat a recovery". *Merrill v. Odiorne*, (1915) 94 A 753 (Me.); *Chubb v. Holmes*, (1930) 150 A 516 (Conn.); *Stacy v. Williams*, (1934) 69 S W (2d) 697 (Ky.); *Duke Sanatorium v. Hearn*, (1932) 13 P (2d) 183 (Okl.); *Champs v. Stone*, (1944) 58 N E (2d) 803 (Ohio); *Johnson v. U.S.*, (1967) 271 F Supp. 205 (U.S.D.C. Ark.); *Shirey v. Schlemmer*, (1967) 223 N E (2d) 759 (Ind.). To the question whether the failure of a parent to follow instructions or co-operate will avail as a contributory negligence defence to an action against the physician, brought on behalf of a child, the answer is affirmative. HOLDER, *loc. cit.* p. 1110; *Cyr v. Landry*, (1915) 95 A 883 (Me.); *Puffinberger v. Day*, (1962) 24 Cal. Rptr. 533; *Contra: Wheatley v. Heidemann*, (1960) 102 N W (2d) 343 (Iowa).

ever, is the situation in which the original injury by the physician is aggravated by the subsequent negligence of the patient[78]. In this case, plaintiff's actions will not bar recovery but only reduce the amount of damages to the extent that they have been aggravated through his fault[79].

As a final point it should be noted that aside from certain jurisdictions which adhere to the theory that freedom from negligence is an essential part of plaintiff's cause of action[80], the great majority feel that the burden of proving contributory negligence will rest upon the physician[81].

(b) Partial liability of the patient

The patient may be required to assume partial responsibility for his own damages along with the negligent practitioner, if in fact, said patient contributed to his injuries by a refusal to co-operate. This would occur in those common law areas such as the Anglo-Canadian provinces[82], England[83] and certain of the American states, which have substituted for the concept of contributory negligence, the doctrine of "comparative negligence"[84]. In the civilian jurisdictions of France and the Province of Quebec, the notion of "*partage de responsabilité*" has long been admitted[85].

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78 HOLDER, *loc. cit.*, p. 785; LOUISELL, WILLIAMS, *op. cit.*, p. 248, no. 9.03; SHORTEL, PLANT, *op. cit.*,p. 153; HOWARD, PARKS, *op. cit.*, p. 193.

79 *Leadingham v. Hillman,* (1928) 5 S W (2d) 1044 (Ky.); *Wemmett v. Mount et al,* (1930) 292 P 93 (Ore.); *Josselyn v. Dearborn,* (1948) 62 A (2d) 174 (Me.); *Flynn v. Stearns,* (1958) 145 A (2d) 33 (N.J.).

80 E.g. *Wilson v. Corbin,* (1950) 41 N W (2d) 702 (Iowa).

81 PROSSER, *op. cit.*, p. 426, no. 64; J.G. FLEMING, *The Law of Torts,* 3rd ed., Sydney, Australia, The Law Book Co., 1965, p. 235; R.A. PERCY, *Charlesworth on Negligence,* 4th ed., London, Sweet and Maxwell Ltd., 1962, p. 519, no. 1115; *Town v. Archer,* (1902) 4 D.L.R. 383 (Ont.); *Summers v. Tarpley,* (1919) 208 S W 266 (Mo.); *Page et al v. Brodoff,* (1961) 169 A (2d) 901 (Conn.).

82 *The Contributory Negligence Act,* R.S.A. 1955, ch. 56 (Alta); *Contributory Negligence Act,* R.S.B.C. 1960, ch. 74 (B.C.); *The Tortfeasors and Contributory Negligence Act,* R.S.M. 1970 ch. T-90 (Man.); *Contributory Negligence Act,* R.S.N.S. 1967, ch. 54 (N.S.); *Contributory Negligence Act,* R.S.N.B. 1952, ch. 36 (N.B.); *The Negligence Act,* R.S.O. 1970, ch. 296 (Ont.); *The Contributory Negligence Act,* R.S.S. 1965, ch. 91 (Sask); *The Contributory Negligence Act,* R.S.N. 1952, ch. 159 (Nfld); *The Contributory Negligence Act,* P.E.R.S. 1951, ch. 30 (P.E.I.).

83 *The Law Reform (Contributory Negligence) Act,* (1945), 8-9 Geo. VI, ch. 28.

84 HOLDER, *loc. cit.*, p. 785.

85 Lyon, 7 jan. 1952; D.1952.97; H. MAZEAUD, L. MAZEAUD, G. MAZEAUD, *Traité théorique et pratique de la responsabilité civile délictuelle et contractuelle,* 6th ed., Paris, Editions Montchrestien, 1970, vol. 2, p. 548, no. 1457; as regards delictual responsibility in Quebec, see *The Nichols Chemical Co. of Canada v. Lefebvre,* (1909) 42 S.C.R. 402 at p. 404. Note that both in France and Quebec, the amount of damages to be awarded will be reduced, if by submitting to treatment or operations involving little risk, the condition of the victim may be improved; Chambery, 22 déc. 1947; D.1948.172; Conseil de Préfecture de Limoges, 22 fév. 1953; G.P.1953.1.250; Angers 19 jan. 1955; J.C.P. 1955.2.8531; Tribunal de Grande

(c) Termination of the physician-patient contract

Since both parties are normally free to terminate the physician-patient relationship at any time, the lack of co-operation on the part of the patient may, in certain circumstances, be construed as a withdrawal of consent[86]. On the other hand, although consent may not be withdrawn, if the physician finds it distasteful to continue with a difficult patient, the *contrat de soins* can still be resiliated unilaterally by said physician[87]. Naturally, a most proper precaution would be to not quit the patient at a critical time without at least providing a suitable replacement[88]. To do otherwise would be to expose oneself to a recourse based on abandonment.

Instance de Laval, 13 fév. 1967; D.S. 1968.39 (note Max LeROY); Cass.crim. 3 juillet 1969; J.C.P. 1970.II.16447 (note R. SAVATIER); A. NADEAU, R. NADEAU, *Traité pratique de la responsabilité civile délictuelle*, Montreal, Wilson & Lafleur Ltd., 1971, p. 551, no. 589 and jurisprudence therein cited.

86 KORNPROBST, *op. cit.*, p. 442; WASMUTH, *op. cit.*, 28.

87 *Beausoleil v. La Communauté de la Charité de la Providence et al*, (1965) Q.B. 37, at page 41.

88 SAVATIER, SAVATIER, AUBY, PEQUIGNOT, *op. cit.*, p. 271, no. 300. The prudent physician would be well advised to send reasonable notice of his intention to withdraw. STETLER, MORITZ, *op. cit.*, pp. 121-122.

Conclusion

One of the most popular criticisms of the medical profession has been that doctors have traditionally arrogated decisional rights more properly left to the patient and his family. In this period of rapid sociological changes, in which words like "participation", "communication", "emancipation" and "dialogue" are quite in vogue, the courts have, on several occasions, reaffirmed the paramount importance of informed or enlightened consent. The judgments in *Halushka v. University of Saskatchewan*[89], *Beausoleil v. Soeurs de la Charité*[90], and *Dame Dufresne v. X*[91], are cases in point.

The *quid pro quo* of this development was the requirement that the truly consenting patient manifest his determination by an indicative personal deportment; or in other words, an attitude of co-operation. Taking note of this evolution, the goal of this paper has been to elevate said duty to co-operate above the level of a pious exhortation and place it in its rightful perspective as one of the patient's legal obligations in the medical contract.

Patients entering large clinics or hospitals often feel a loss of dignity as they are prodded, pricked, connected to machines or otherwise manipulated by the rather business-like medical staff. Although one is obliged to co-operate, perhaps it is of some consolation that one is not at present legally bound to like it.

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89 (1965) 53 D.L.R. (2d) 436 (Saskatchewan Court of Appeals).

90 (1965) Q.B. 37, especially the opinion of Owen J., at p. 51.

91 (1961) S.C. 119.