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Shorter v. Drury: Refusal to Permit Treatment Constitutes Express Assumption of Risk Which Can Reduce the Liability of a Negligent Physician

Alisa Beth Arnoff

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Shorter v. Drury: Refusal to Permit Treatment Constitutes Express Assumption of Risk Which Can Reduce the Liability of a Negligent Physician

I. INTRODUCTION

With medical malpractice litigation rapidly increasing, measures are needed to ensure that damages are equitably apportioned among the litigants. Various legislatures have enacted statutes to reduce both the filing of malpractice claims and the amount recoverable in malpractice actions, but the issue of apportionment of liability has been left to the comparative fault laws of each jurisdiction. The common-law defense of express assumption of risk,

1. See P. Danzon, The Frequency and Severity of Medical Malpractice Claims (1982); 10 Med. Liab. (Cap.) 1 (Jan. 1985) (patients are filing three times as many claims as they did ten years ago; in 1983, 16 claims were filed per 100 physicians); 9 Med. Liab. (Cap.) 1 (Nov. 1984) (one claim is now filed per 12 physicians); see also Raspberry, Litigation Fever: what remedy? Chi. Tribune, Nov. 12, 1985, at 21, col. 3.


3. See infra notes 20-27 and accompanying text.
however, also can help produce equitable apportionment of damages.\textsuperscript{5} The successful assertion of express assumption of risk reduces the plaintiff’s recovery in situations in which the plaintiff knowingly and voluntarily consented to encounter a specific risk associated with medical treatment.\textsuperscript{6}

Medical professionals can raise the defense in situations in which a patient has exercised his right to refuse a particular form of medical treatment and has been injured as a result of his refusal.\textsuperscript{7} The physician should require that the patient document his refusal to the procedure.\textsuperscript{8} The validity of a refusal form as a manifestation of express assumption of risk was first litigated before a state court of last resort in \textit{Shorter v. Drury}.\textsuperscript{9} The Supreme Court of Washington considered whether a patient’s express refusal to accept a blood transfusion relieved the physician from all consequences resulting from the refusal.\textsuperscript{10} The court held that a refusal form signed by the patient and her husband was valid,\textsuperscript{11} and that the patient had expressly assumed the consequences of her refusal.\textsuperscript{12}

This note will examine the validity of a refusal as a damage-reducing factor in medical malpractice actions. The note first will discuss whether express assumption of risk survived the adoption of comparative fault systems in various states. Next, the note will review the history of assumption of risk in medical malpractice actions. The patient’s constitutional right to refuse treatment will be compared with the conflicting interests of the state and the medical profession. The patient’s duty to mitigate his damages also will be reviewed. This note will then discuss the \textit{Shorter} court’s decision that a refusal to accept treatment constitutes a damage-reducing express assumption of risk. After analyzing the decision’s shortcomings, the note will suggest that patients who refuse treatment should suffer the consequences of their failure to mitigate damages. This note will conclude with a discussion of the \textit{Shorter} holding’s potential impact on medical malpractice litigation and on the ethical dilemma faced by hospitals and physicians whose patients refuse treatment.

\begin{enumerate}
\item See infra notes 15-18 and accompanying text.
\item See infra notes 28-40 and accompanying text.
\item See infra notes 33-40 and accompanying text.
\item See infra notes 41-66 and accompanying text.
\item See infra note 52 and accompanying text.
\item 103 Wash. 2d 645, 695 P.2d 116, cert. denied, 106 S. Ct. 86 (1985).
\item Id. at 650-53, 695 P.2d at 119-21.
\item Id. at 651, 695 P.2d at 120.
\item Id. at 659, 695 P.2d at 124.
\end{enumerate}
II. BACKGROUND

A. The Interaction Between Express Assumption of Risk and Comparative Negligence

The adoption of comparative fault standards threatened the survival of assumption of risk as an affirmative defense. At common law, assumption of risk once served as a total bar to recovery. In order to allege that the plaintiff had assumed the risk of the defendant's conduct, the defendant had to establish that the plaintiff knew and understood the specific risk to which he had consented to expose himself. In addition, the plaintiff had to have chosen voluntarily to incur that specific risk.

The courts have recognized both express and implied assumption of risk. Express assumption of risk involves an oral or written manifestation of consent to encounter a specific risk, a consent which relieves the defendant from liability for injuries arising from the conduct that gives rise to the risk. Implied assumption of risk also involves a voluntary submission to the conduct of another party, but this consent is manifested simply through conduct, not through an express agreement.

The adoption of comparative fault generally eliminated the use

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13. See infra notes 20-27 and accompanying text. The various jurisdictions have entitled their comparative fault acts differently. Some jurisdictions refer to "comparative fault," see, e.g., IND. CODE ANN. § 34-4-33-4 (West Supp. 1985); WASH. REV. CODE ANN. § 4.22.005 (Supp. 1986), while others refer to "comparative negligence," see, e.g., MASS. GEN. LAWS ANN. ch. 231, § 85 (West Supp. 1974); NEV. REV. STAT. § 41.141 (1973). There is no appreciable difference between the two phrases. This note will use the phrase "comparative fault" to describe the laws in both of these types of jurisdictions.

14. See infra notes 28-32 and accompanying text.


19. See Duffy v. Midlothian Country Club, 135 Ill. App. 3d 429, 433, 481 N.E.2d 1037, 1041 (1985) (attendance at golf tournament was conduct through which plaintiff impliedly assumed risk of being struck by golf ball); RESTATEMENT (SECOND) OF TORTS § 496C (1965).
of assumption of risk as a complete bar to recovery. Comparative fault requires that the conduct of the plaintiff and the defendant be compared for the purpose of equitably distributing liability. The plaintiff's damages are reduced by the percentage of total fault attributable to his own conduct.

American jurisdictions have adopted several different comparative fault standards. The "pure" comparative fault jurisdictions, for example, allow a plaintiff to recover something unless his own conduct was the sole cause of his injuries. Many states, however, allow the plaintiff to recover only if his culpability is less than or equal to that of the defendant. Other states limit recovery to situations in which the plaintiff's fault is less than that of the defendant. Two states have adopted what has come to be referred to as the "slight-gross" approach: the plaintiff can recover only if his

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23. See infra notes 24-27 and accompanying text. The following jurisdictions have declined to adopt comparative fault: Alabama, Delaware, District of Columbia, Maryland, North Carolina, South Carolina, Tennessee and Virginia. See generally H. Woods, supra note 21.


26. These states are referred to as the "not as great as" jurisdictions. See Bradley v. Appalachian Power Co., 256 S.E.2d 879 (W. Va. 1979); ARK. STAT. ANN. § 27.1764 (1979); Colo. REV. STAT. § 13-21-111 (Supp. 1985); GA. CODE ANN. § 105-603 (1984); IDAHO CODE § 6-801 (1979); KAN. STAT. ANN. § 60-258(a) (1983); ME. REV. STAT. ANN. tit. 14, § 156 (1980); N.D. CENT. CODE § 9-10-07 (Supp. 1985); 42 PA. CONS. STAT. ANN. § 7102(a) (Purdon 1982); TEX. STAT. ANN. art. 33.001 (Vernon Supp. 1986); UTAH CODE ANN. § 78-27-37 (1977); WYO. STAT. § 1-1-109(a) (1977).
fault is slight when compared with that of the defendant.  

Various states have reached different conclusions as to whether express assumption of risk has survived the adoption of comparative fault. The defense remains viable in nearly a quarter of the states. Some of these jurisdictions limit the use of express assumption of risk to situations involving a contractual relationship. In other states, the plaintiff's express assumption of risk is treated as a distinct type of fault to be compared with the defendant's conduct; it is not characterized as a form of contributory negligence. Most jurisdictions, however, have not yet determined whether express assumption of risk has survived the adoption of comparative fault.

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B. Express Assumption of Risk In Medical Malpractice Actions

When a physician raises the assumption-of-risk defense, he must establish that the patient knew of and understood the specific risk which led to the injury. The patient generally has no medical training, and therefore must depend on the physician to perform his professional duty of acquainting the patient with the risks of proposed procedures so that the patient can make an informed decision about his treatment. If the physician fails in this duty, the patient cannot later be held to have assumed a risk which he neither knew nor appreciated.

No reported case construing any of these statutes discusses the survival of express assumption of risk. The jurisdictions which have not specifically addressed the survival of express assumption of risk are Alaska, Arizona, Colorado, Georgia, Hawaii, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, North Dakota, Rhode Island, South Dakota, Vermont, and Wyoming. See generally H. Woods, supra note 21. Perhaps the defense has been abolished or perhaps it retains its own legal identity, separate from other forms of comparative fault.

See generally D. Louisell & H. Williams, 1 Medical Malpractice § 9.02 (1985); Annot., 50 A.L.R.2d 1043 (1956).


See In re Brown, 478 So. 2d 1033, 1040 (Miss. 1985); Prosser and Keeton, supra note 16, at 189-92. The physician's disclosure must be one which a reasonable physician would make under similar circumstances.

See, e.g., Canterbury v. Spence, 464 F.2d 772, 788 (D.C. Cir.) (a physician has no duty to inform a patient of dangers "of which persons of average sophistication are aware"), cert. denied, 409 U.S. 1064 (1972); Margaret S. v. Edwards, 488 F. Supp. 181, 207 (E.D. La. 1980) (doctor and patient have fiduciary relationship; the aim of informed consent is to ensure that the patient is aware of the risks related to the procedure and to receive his agreement to encounter those risks); Martin v. Bralliar, 540 P.2d 1118, 1120 (Colo. Ct. App. 1975) (physician's duty includes informing the patient of the general and specific risks associated with the procedure; the communication of the general risks does not satisfy the duty to disclose the specific risks); Micekis v. Field, 37 Ill. App. 3d 763, 768, 347 N.E.2d 320, 324 (1976) (physician's duty requires an exercise of discretion with respect to prudent disclosure of the risks based on the patient's best interests). But see Padgett v. Ferrier, 172 Ga. App. 335, 323 S.E.2d 166 (1984) (Georgia does not recognize "informed consent" as a viable legal principle in medical malpractice actions).

See, e.g., King v. Solomon, 323 Mass. 326, 329, 81 N.E.2d 838, 840 (1948) (physician allowed his patient to become addicted to drugs); Los Alamos Medical Center v. Coe, 58 N.M. 686, 692-94, 275 P.2d 175, 179-80 (1954) (same); Suria v. Shiffman, 107 A.D.2d 309, 312, 486 N.Y.S.2d 724, 727 (1985) (transsexual held not to have assumed the present surgical risks created by his prior participation in a silicone treatment program when he was not cognizant of the risks involved); Largess v. Tatum, 130 Vt. 271, 279-80, 291 A.2d 398, 403 (1972) (plaintiff did not assume risk of refracturing hip after physician failed to warn her to keep weight off it).
Of course, it is critical to recognize that a patient cannot assume the risk of the physician's negligence. Assumption of risk in a medical malpractice action can only be found when the patient has agreed to encounter an already-existing risk. The patient will be held to have assumed the risks flowing from the preexisting situation if he was fully cognizant of the risks involved and if he voluntarily chose to encounter them.

C. The Constitutional Right to Refuse Medical Treatment

Assumption-of-risk cases involving refusals may implicate at least two constitutional rights of patients. The first of these is the qualified right to the free exercise of religion. This right is a bifurcated guarantee encompassing two different freedoms: the freedom to believe and the freedom to act. The former is absolute, but the latter is conditioned upon the particular circumstances surrounding the citizen's exercise of his convictions. The second constitutional right at issue in some refusal cases is the right to bodily privacy. Both of these constitutional rights can be implicated when a patient refuses medical treatment and the state issues a court order compelling treatment.

40. See, e.g., Champs v. Stone, 74 Ohio App. 344, 58 N.E.2d 803 (1944) (plaintiff who submitted to blood test fully aware that doctor was "grossly intoxicated" assumed risk of complications).
41. See infra notes 42-60 and accompanying text.
42. See In re Brown, 478 So. 2d 1033, 1036 (Miss. 1985). The first amendment to the United States Constitution provides that "Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof. ..." U.S. CONST. amend. I.
45. The fourth, fifth, ninth and fourteenth amendments create a right to privacy. See Roe v. Wade, 410 U.S. 113, 153 (1973) (penumbra in the Bill of Rights guarantees a woman a qualified right to terminate her pregnancy); Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (certain privacies are created by several fundamental guarantees); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977) ("unwritten constitutional right of privacy found in the penumbra of specific guarantees found in the Bill of Rights").
46. See, e.g., Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000, 1007 (D.C. Cir.) (order granted to allow blood transfusion of adult), reh'g
The rights to the free exercise of religion and to bodily privacy can provide the patient with an opportunity to refuse medical treatment. The patient's express consent to the treatment is required to prevent a subsequent allegation of battery; hospitals have a duty to protect patients from being subjected to bodily contacts to which they have not assented. But a patient may refuse treatment because his religion prohibits medical intervention or denied.

47. See, e.g., Jehovah's Witnesses v. King County Hosp., 278 F. Supp. 488, 500-05 (W.D. Wash. 1967) (plaintiffs alleged that juvenile court law which authorized removal of the children of Jehovah's Witnesses from the custody of their parents for purposes of medical treatment violated the parents' rights to the free exercise of religion and against the establishment of religion, as well as their rights to bodily and family privacy), aff'd, 390 U.S. 598, reh'g denied, 391 U.S. 961 (1968); People ex rel. Wallace v. LaBrenz, 411 Ill. 618, 104 N.E.2d 769, 772 (1952) (court appointed guardian to authorize transfusion of child); Mercy Hosp., Inc. v. Jackson, 62 Md. App. 409, 417-18, 489 A.2d 1130, 1134 (Ct. Sp. App. 1985) (appointment of guardian denied for pregnant woman in need of transfusion where fetus was not endangered); In re Brown, 478 So. 2d 1033, 1035 (Miss. 1985) (State ordered witness transfused against her will so she could testify in a criminal trial); Morrison v. State, 252 S.W.2d 97, 98 (Mo. 1952) (infant adjudged state ward for purpose of administering vital transusions); John F. Kennedy Memorial Hosp. v. Heston, 38 N.J. 576, 579, 279 A.2d 670, 671 (1971) (guardian appointed to authorize transusions for unconscious adult, over parents' objections); Application of Winthrop Univ. Hosp., 128 Misc. 2d 804, 804-05, 490 N.Y.S.2d 996, 996-97 (Sup. Ct. 1985) (court authorized transusion for adult patient if necessary to save her life during surgery); Application of Jamaica Hosp., 128 Misc. 2d 1006, 1008, 491 N.Y.S.2d 898, 900 (Sup. Ct. 1985) (transution ordered to protect life of midterm fetus); Crouse Irving Memorial Hosp., Inc. v. Paddock, 127 Misc. 2d 101, 103, 485 N.Y.S.2d 443, 446 (Sup. Ct. 1985) (court ordered transusion during caesarean operation to safeguard lives of both mother and infant); see generally Annot., 9 A.L.R.3d 1391 (1966).


The majority of the "refusal" cases involve Jehovah's Witnesses, members of a fundamentalist Christian society who believe that the ingestion of the blood of another creature is strictly prohibited by the Bible, and that the free exercise clause of the first amendment protects them against blood transusions. See People ex rel. Wallace v. LaBrenz, 411 Ill.
because he believes that the treatment will violate his right to bodily privacy.\textsuperscript{51} If a patient refuses the recommended treatment, the physician should require that the refusal be documented\textsuperscript{52} and recorded in the patient's medical record.\textsuperscript{53}

The constitutional guarantees which afford a patient the right to refuse treatment often conflict with other important interests. For example, the state is interested in maintaining the ethical integrity of the medical profession.\textsuperscript{54} The state also is committed to preserving the health and lives of its citizens.\textsuperscript{55} Similarly, the medical

\begin{itemize}
\item \textsuperscript{52} WISCONSIN Hosp. ASS'N, CONSENT MANUAL 13 (1969). One hospital association has recommended the following form:
\begin{quote}
I, \underline{(patient's name)}, refuse to allow anyone except the physician of my choice to examine and treat me. The risks attendant to my refusal have been fully explained to me and I fully understand that I will in all probability need \underline{(briefly cite treatment indicated and time element involved)}
\end{quote}
and that if the same is not done, my chances for regaining normal health are seriously reduced, and that in all probability, my refusal for such treatment or procedure (may) (will) seriously imperil my life . . . .
\item \textsuperscript{53} NORTH DAKOTA Hosp. ASS'N, CONSENT MANUAL 16 (1968). If the patient refuses to sign a refusal form, the consent form should be read aloud to him in the presence of witnesses, and this communication should be recorded on the form and in the patient's medical record. WISCONSIN Hosp. ASS'N, CONSENT MANUAL 13 (1969).
\item \textsuperscript{54} Satz v. Perlmutter, 362 So. 2d 160, 163-64 (Fla. Dist. Ct. App. 1978).
\item \textsuperscript{55} Id. at 162. This interest is especially prevalent when the lives of children are involved because the state, occupying the position of \textit{paren\textacute{s patriae}}, is obliged as a parent to all children to defend the rights of the child. A. KADUSHIN, CHILD WELFARE SERVICES 151 (3d ed. 1980).
\end{itemize}
community strives to maintain the health of society. In certain circumstances, such as when the life of an individual is threatened, some courts have held that these interests override the citizen’s constitutional rights to refuse treatment.

The state may choose to intervene and authorize treatment despite the patient’s refusal. In the typical case, the hospital seeks a court order authorizing treatment over the patient’s objections. The patient may subsequently file suit against the hospital or physician, alleging that his constitutional rights have been violated by the court-ordered treatment.

The availability of a refusal form which doubles as a release

56. See American Medical Ass’n, Principles of Medical Ethics (1982).


One court utilized the parens patriae theory, see supra note 55, to order a transfusion of an adult patient in order to protect the patient’s children, because her death would put the burden of child-rearing upon the state. Application of Winthrop Univ. Hosp., 128 Misc. 2d 804, 806-07, 490 N.Y.S.2d 996, 996-97 (Sup. Ct. 1985).
60. See, e.g., In re Brooks’ Estate, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (husband appealed appointment of conservator for his wife, alleging violation of first amendment right to free exercise of religion); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (incompetent persons retain right of privacy to refuse unwanted medical treatment, even though refusal is based on substituted judgment of court-appointed guardian ad litem).

Such suits may be brought under the Civil Rights Act of 1972, 42 U.S.C. § 1983 (1982), which provides in relevant part:

(E)very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law...

Id.

See, e.g., Holmes v. Silver Cross Hosp., 340 F. Supp. 125 (N.D. Ill. 1972) (administr-
from liability can render court authorization unnecessary. When determining the validity of a medical liability release, courts focus primarily on the bargaining power of the medical service entity and the public's ability to protect itself from that power. The courts have held that "blanket releases," which purport to relieve hospitals or physicians from liability for negligence, are contrary to the public interest and hence are void. The courts, however, have

trix alleged that decedent's right to religious freedom was violated by private defendants acting under color of state law).


A standard refusal form used by a Chicago hospital provides as follows:

I request that no blood or blood derivations other than homologous (my own) be administered to during this hospitalization, notwithstanding that such treatment may be deemed necessary in the opinion of the attending physician or his assistants to preserve life, or promote recovery. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivations and I fully understand the possible consequences or such refusal on my part.

Illinois Masonic Medical Center (1986). But see the model form suggested by the Illinois Institute for Continuing Legal Education (ICLE), which does not contain language relieving the physician or hospital from liability:

I have considered the nature of my condition, the recommended course of treatment, the alternative methods of treatment, including non-treatment, and the general hazards associated therewith. After careful consideration, I have decided to withhold consent to the performance of the following upon myself/the patient: ____________________________

I realize I may, at any time, revoke my refusal and, thereafter, consent to treatment by so notifying my physician, some other member of the Hospital Medical Staff, or another professional employee of the Hospital.


63. Other considerations may include: (1) whether the medical entity is suited to public regulation, (2) whether the entity offers an important public service, and (3) whether the entity is willing to accommodate the needs of the public. See Tunkl v. Regents of Univ. of Cal., 60 Cal. 2d 92, 98-101, 383 P.2d 441, 445-46, 32 Cal. Rptr. 33, 37-38 (1963); Porubiansky v. Emory Univ., 156 Ga. App. 602, 607-09, 275 S.E.2d 163, 167-68 (1980), aff'd, 248 Ga. 391, 282 S.E.2d 903 (1981); Olson v. Molzen, 558 S.W.2d 429, 431 (Tenn. 1977).

not yet been presented with a "blanket release" which contains language of refusal. A refusal should relieve medical professionals from liability for the risks assumed by a patient who refuses to accept treatment.

D. Mitigation of Damages

Although a patient has a right to refuse medical treatment, a patient who exercises this right has an obligation to minimize the injuries that he will incur as a result of his refusal. This obligation is based on the contractual duty to mitigate damages, and is referred to in the torts context as the doctrine of "avoidable consequences." The patient has a duty to take reasonable steps to avoid being injured or increasing the severity of his injuries. If the patient fails to take advantage of a reasonable opportunity to mitigate his damages, he is barred from recovering for that portion of his injuries which could have been avoided. The defendant has the burden of establishing that the plaintiff failed to mitigate his damages.

When the patient's religious beliefs cause him to refuse treatment, the courts will examine the circumstances underlying the refusal in order to determine whether a reasonable opportunity to mitigate existed. The free exercise clause precludes the courts relieved physician and staff from liability for all complications associated with abortion for the two years following the procedure. See generally Annot., 6 A.L.R.3d 704 (1966). Brief of Respondents at 32, Shorter v. Drury, 103 Wash. 2d 645, 695 P.2d 116 (1985).

See infra notes 170-82 and accompanying text.

See generally 3 PERSONAL INJURY—Actions, Damages, Defenses §§ 4.01, 4.02 (L. Frumer & M. Friedman eds. 1984) [hereinafter cited as PERSONAL INJURY]. See W. PROSSER, HANDBOOK OF THE LAW OF TORTS 422-23 (1971); S. SCHREIBER, DAMAGES IN PERSONAL INJURY 25-26 (1965).

Douglass v. Hustler Magazine, Inc., 769 F.2d 1128, 1144 (7th Cir. 1985); see also Clarkson v. Wright, 108 Ill. 2d 129, 131-38, 483 N.E.2d 268, 269-72 (1985) (majority and dissenting opinions discuss mitigation-of-damages doctrine in reference to "seatbelt defense").

Douglass v. Hustler Magazine, Inc., 769 F.2d 1128, 1144 (7th Cir. 1985); see also supra note 68.


3 PERSONAL INJURY, supra note 67, at § 4.01[2]; see Slater v. Chicago Transit Auth., 5 Ill. App. 2d 181, 185, 125 N.E.2d 289, 291 (1955).

from considering whether a person's religious beliefs are reasonable. The patient, however, possesses no right to impose liability upon a third party when that liability results solely from the patient’s religious beliefs.

III. SHORTER v. DRURY

A. The Facts

Elmer and Doreen Shorter were Jehovah's Witnesses whose religious beliefs forbade the receipt of blood transfusions. Mrs. Shorter initially consulted the defendant, Dr. Drury, while she was pregnant. Dr. Drury recommended a surgical procedure, dilation and curettage, after discovering that Mrs. Shorter had suffered a "missed abortion." Of the three methods available to perform this procedure, the doctor only discussed one — the curette method — with the Shorters. The doctor warned the couple that both internal bleeding and puncture of the uterus might result from this procedure. Mrs. Shorter consulted another doctor for a second opinion; he reconfirmed the possibility that bleeding could develop.

Despite the risks inherent in the operation, Doreen Shorter decided to proceed. She and her husband signed a form releasing the hospital, its staff and the attending physician from liability for the consequences of the Shorters' refusal to permit a blood transfusion. During the operation, Dr. Drury punctured the patient's

generally 2 DAMAGES IN TORT ACTIONS, supra note 18, at § 16.31; Note, Medical Care, Freedom of Religion, and Mitigation of Damages, 87 YALE L.J. 1466 (1978).


78. Id. at 647, 615 P.2d at 118.

79. Id.

80. Id. The procedure may be performed by a curette, by suction or with suppositories. Id.

81. Id. at 647-48, 695 P.2d at 118.

82. Id. at 648, 695 P.2d at 118.

83. Id.

84. Id. at 648, 695 P.2d at 118-19. All three methods presented the risk of bleeding: the method chosen by the defendant posed the highest risk. Id. at 647-48, 695 P.2d at 118.

85. Id. at 648-49, 695 P.2d at 119. The following release was completed by the Shorters:

GENERAL HOSPITAL OF EVERETT

Refusal to Permit Blood Transfusion

Date November 30, 1979 Hour 6:15 a.m.
uterus, causing uncontrollable bleeding. The physician informed the patient of the extreme gravity of the situation — the continuous loss of blood threatened her life and a blood transfusion was vital. A fully cognizant Doreen Shorter refused to permit the transfusion, as did her husband. Even though the doctors surgically repaired the uterus without administering blood, Doreen Shorter bled to death.

Notwithstanding his failure to consent to the procedure, Elmer Shorter filed a wrongful death medical malpractice action, alleging that Dr. Drury had been negligent and had failed in his duty of informed consent. The defendant denied any negligence, maintained that the release form relieved him from liability as a matter of law, and asserted the affirmative defense of assumption of risk. Dr. Drury argued that even if the Shorters' assumption of risk did not totally bar recovery, it should at least reduce the amount of damages entered against him. The jury found that the defendant's negligence had proximately caused Mrs. Shorter's death and set damages at $412,000. They reduced these damages by seventy-five percent, however, because they determined that the Shorters "knowingly and voluntarily" assumed the risk

I request that no blood or blood derivatives be administered to Doreen V. Shorter during this hospitalization. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives and I fully understand the possible consequences of such refusal on my part.

[/s/ Doreen Shorter]
Patient

[/s/ Elmer Shorter]
Patient's Husband or Wife

Spousal consent is sought in two situations: when the reproductive capacity of one spouse may be affected by the procedure, and when the patient may be unable to give effective consent. See NORTH DAKOTA HOSP. ASS'N, CONSENT MANUAL 14 (1968).

86. Shorter, 103 Wash. 2d at 649, 695 P.2d at 119.
87. Id.
88. Id.
89. Id.
90. Brief of Respondents at 4, Shorter v. Drury, 103 Wash. 2d 645, 695 P.2d 116 (1985). The suit was brought pursuant to Washington's wrongful death statute, which states that "when the death of a person is caused by the wrongful act, neglect or default of another, his personal representative may maintain an action for damages against the person causing his death." WASH. REV. CODE § 4.20.010 (1974).
92. Id. at 5-6.
93. Id. at 6-7.
94. Shorter, 103 Wash. 2d at 649, 695 P.2d at 119.
95. Id.
that Mrs. Shorter might die from blood loss.\textsuperscript{96}

\section*{B. The Decision of the Washington Supreme Court}

On appeal to the Supreme Court of Washington, Mr. Shorter argued that the release form violated public policy\textsuperscript{97} and that express assumption of risk failed to survive the enactment of Washington's comparative negligence statute.\textsuperscript{98} The defendant cross-appealed, contending that assumption of risk constituted a complete bar to recovery.\textsuperscript{99}

The court found that the release was valid.\textsuperscript{100} It held that the jury could have found that the Shorters had voluntarily executed the release.\textsuperscript{101} The court found that both of the doctors consulted had apprised Mrs. Shorter of the risk of bleeding associated with the procedure\textsuperscript{102} and that she was fully aware of the specific risk of death by blood loss.\textsuperscript{103} Furthermore, the court found that the Shorters voluntarily signed the release form in response to their religious beliefs, not in response to any compulsion created by the defendant.\textsuperscript{104}

The court also held that the refusal form did not violate public policy.\textsuperscript{105} The form did not purport to release the physician from the consequences of his negligence;\textsuperscript{106} instead the release was limited specifically to the consequences of the refusal to accept blood.\textsuperscript{107} Additionally, the court found that the refusal provided the defendant with a viable alternative to either refusing to treat the patient or seeking a court order to transfuse the patient against her will.\textsuperscript{108}

The court next held that assumption of risk survived the advent of comparative negligence.\textsuperscript{109} The court, however, distinguished

\begin{itemize}
\item \textsuperscript{96} \textit{Id.} at 649-50, 695 P.2d at 119.
\item \textsuperscript{97} \textit{Id.} at 650, 695 P.2d at 119.
\item \textsuperscript{98} \textit{Id.} at 653, 695 P.2d at 121.
\item \textsuperscript{99} \textit{Id.} at 647, 695 P.2d at 118.
\item \textsuperscript{100} \textit{Id.} at 651, 695 P.2d at 120.
\item \textsuperscript{101} \textit{Id.}
\item \textsuperscript{102} \textit{Id.} at 657, 695 P.2d at 123.
\item \textsuperscript{103} \textit{Id.} at 652, 695 P.2d at 120.
\item \textsuperscript{104} \textit{Id.}
\item \textsuperscript{105} \textit{Id.}
\item \textsuperscript{106} The court emphasized this point three times. See \textit{id.} at 650-52, 695 P.2d at 120; see also \textit{supra} notes 63-64 and accompanying text.
\item \textsuperscript{107} \textit{Shorter}, 103 Wash. 2d at 652, 695 P.2d at 120.
\item \textsuperscript{108} \textit{Id.} at 652, 695 P.2d at 120-21.
\item \textsuperscript{109} \textit{Id.} at 654-55, 695 P.2d at 122 (citing Lyons v. Redding Constr. Co., 83 Wash. 2d 86, 95, 515 P.2d 821, 826 (1973)).
\end{itemize}
express assumption of risk from contributory negligence,\textsuperscript{110} holding that the former was a type of consent or waiver, not negligence.\textsuperscript{111}

The court then examined whether the jury could have found that the Shorters had expressly assumed the risk of death from bleeding.\textsuperscript{112} The court found that the three elements of assumption of risk — knowledge, understanding and voluntary encounter — were present to support such a finding.\textsuperscript{113} According to the court, the Shorters were sufficiently advised of the specific possibility of fatal bleeding as a result of the operation.\textsuperscript{114} The record contained enough evidence to support the jury’s conclusion that the Shorters had understood that risk,\textsuperscript{115} and that they had voluntarily assumed the risk of Mrs. Shorter’s death by blood loss as a result of their refusal to authorize a blood transfusion.\textsuperscript{116}

\textbf{C. The Dissenting Opinion}

A substantial minority of the court\textsuperscript{117} found that the majority holding had excused the physician from liability for his negligence.\textsuperscript{118} The dissent stated that the majority had failed to distinguish between the two situations in which the need for blood might arise: the normal, non-negligent performance of the operation and the negligent performance that actually caused the blood loss.\textsuperscript{119} The minority urged that the Shorters’ assumption of the risk of death from blood loss was limited solely to the former scenario.\textsuperscript{120} The dissent stated that express assumption of risk requires assent not only to a specific type of risk but also to the magnitude of the risk.\textsuperscript{121} Dr. Drury’s negligence increased the magnitude of the risk to which the Shorters had assented, and therefore, the dissenters maintained, the risk created was not one which the Shorters had assumed.\textsuperscript{122}

\textsuperscript{110} Shorter, 103 Wash. 2d at 656, 695 P.2d at 122.
\textsuperscript{111} Id.
\textsuperscript{112} Id. at 656, 695 P.2d at 123.
\textsuperscript{113} Id. at 656-59, 695 P.2d at 123-24.
\textsuperscript{114} Id.
\textsuperscript{115} Id.
\textsuperscript{116} Id.
\textsuperscript{117} The Court was divided five to four. Id. at 660, 662, 695 P.2d at 124, 126.
\textsuperscript{118} Id. at 660, 695 P.2d at 124 (Pearson, J., dissenting).
\textsuperscript{119} Id. at 660-61, 695 P.2d at 125.
\textsuperscript{120} Id.
\textsuperscript{121} Id.
\textsuperscript{122} Id. at 661, 695 P.2d at 125.
IV. Analysis

In Shorter, the Washington Supreme Court reached the right result for the wrong reasons. The court correctly held that a knowing and voluntary refusal to permit treatment can reduce the liability of a negligent physician.\(^{123}\) The majority, however, relied on faulty reasoning when it found that Mrs. Shorter, by signing the refusal form, expressly assumed the risk of death from failure to receive a transfusion, notwithstanding the defendant's negligence.\(^{124}\) In its analysis, the court ignored Mrs. Shorter's oral refusal to receive blood after the negligently performed operation, a refusal which provided a much stronger basis for a finding of express assumption of risk.\(^{125}\) In relying on the refusal form, the court appeared to hold that the Shorters had assumed the risk of the doctor's negligence, a result which would violate public policy.\(^{126}\) Finally, the doctor never argued, and thus the court did not reach, the issue of the Shorters' failure to mitigate their damages, a failure which fully justified a reduction in the doctor's liability.\(^{127}\)

A. Assumption of the Risk of Death by Blood Loss

The court held that the Shorters had expressly assumed the specific risk that Mrs. Shorter could die as a result of refusing to authorize blood transfusions.\(^{128}\) There were three points in time at which the Shorters indicated that they would refuse to authorize blood transfusions: during consultations with the doctors before Mrs. Shorter entered the hospital,\(^{129}\) when the couple signed the refusal form,\(^{130}\) and after Dr. Drury's negligence had occurred.\(^{131}\) The court, however, discussed only the consultations and the written release in finding that the elements of express assumption of risk were established.\(^{132}\) While the court's reliance on the refusal form may have been mistaken, the subsequent oral refusal ignored by the court clearly established that the Shorters had expressly as-
sumed the specific risk of Mrs. Shorter's death from bleeding as a result of their failure to authorize a blood transfusion.

The Shorters' consultations with two doctors before Mrs. Shorter entered the hospital supported the court's finding that the decision to refuse a transfusion was made with both knowledge and an understanding of the possible consequences. \[^{133}\] Dr. Drury explained to the Shorters that fatal bleeding might occur during the course of a non-negligently performed operation if transfusions were not administered. \[^{134}\] The second physician consulted by the couple confirmed this possibility. \[^{135}\] The Shorters, therefore, knew and appreciated the specific risk that the operation could cause fatal bleeding. \[^{136}\]

The prehospitalization consultations also provided some support for the court's finding that the Shorters' assumption of risk was "voluntary." \[^{137}\] Mrs. Shorter informed Dr. Drury during her initial consultation that her religious beliefs would prevent her from accepting a blood transfusion. \[^{138}\] At first glance, this "compulsion" to remain bound to her religious beliefs appears to be one which would render her action involuntary. That, however, is not the case since Mrs. Shorter freely chose to follow the tenets of the Jehovah's Witness faith. Thus, before Mrs. Shorter entered the hospital, the Shorters knew and understood the risk of refusing blood and appeared ready to voluntarily assume that risk.

Moreover, the language of the hospital release form specifically stated that the couple understood and appreciated the consequences of their refusal. \[^{139}\] It is not as clear, however, that the Shorters voluntarily signed the release form. Mr. Shorter admitted that Dr. Drury neither asked the Shorters to sign the form nor requested that the hospital have the couple complete it. \[^{140}\] The form, however, was provided by the hospital, \[^{141}\] thus putting the Shorters into a situation in which they had little bargaining

\[^{133}\] Id.
\[^{134}\] Id. at 647-48, 695 P.2d at 118.
\[^{135}\] Id. at 648, 695 P.2d at 118.
\[^{136}\] Id. at 657, 695 P.2d at 123.
\[^{137}\] Id. at 651, 695 P.2d at 120.
\[^{139}\] See supra note 85.
\[^{141}\] Id. at 64.
power. To the extent that completion of the form was a precondition to surgery, the Shorters' lack of bargaining power might have rendered the release invalid as against public policy. Thus, while the Shorters' prehospitalization statements indicated that they would voluntarily assume the risks of refusing blood transfusions, the actual signing of the release form may not have been free from compulsion.

The most critical refusal was the third refusal, which occurred after the doctor lacerated the patient's uterus. The Shorters chose to remain exposed to the risk created by their refusal and the doctor's negligence. Their decision to adhere to their religious beliefs was voluntary, and it resulted from reasoning identical to that supporting Mrs. Shorter's comments during the initial consultations. In addition, sufficient evidence established that the Shorters knew of and appreciated the risk of death at this juncture. All of the elements of express assumption of risk were therefore present. Thus, despite some questionable findings as to the validity of the release form, the court correctly concluded that the refusal to authorize treatment supported a reduction in the damages awarded to the plaintiff, who with his wife expressly assumed the risks resulting from the refusal.

B. Release from Negligence

Even if the refusal form represented a knowing and voluntary decision by the Shorters, it violated public policy if it released Dr. Drury from liability for his negligence. While the Shorters could expressly assume the risk of death as a consequence of their refusal, they could not assume the risk of the doctor's negligence. But the physician's negligence, not the refusal or a non-negligently performed operation, created the grave need for blood. Thus, by holding that the Shorters assumed the risk of blood loss caused by an operation which admittedly was negli-

143. See supra notes 63-64 and accompanying text.
144. See supra notes 137-38 and accompanying text.
145. Shorter, 103 Wash. 2d at 649, 695 P.2d at 119.
146. See supra notes 137-38 and accompanying text.
147. Shorter, 103 Wash. 2d at 649, 695 P.2d at 119.
148. Id. at 660, 695 P.2d at 124 (Pearson, J., dissenting); see supra notes 63-64 and accompanying text.
149. Shorter, 103 Wash. 2d at 659, 695 P.2d at 124.
150. Id. at 660, 695 P.2d at 124 (Pearson, J., dissenting).
151. Id.
gently performed, the court arguably was holding, in violation of public policy, that the Shorters had assumed the risk of the doctor's negligence.

The language of the refusal form itself was of little help in determining the scope of the release. The form failed to differentiate between a transfusion made necessary by unavoidable bleeding and one made necessary by a negligently performed operation. By effectively interpreting the form as covering the latter situation, the court allowed Dr. Drury to be released from liability for the consequences of his negligence, despite the court's own holding that the Shorters had not assumed the risk of negligence.

C. Failure to Mitigate Damages

The court could properly have analyzed the combined effect of the Shorters' express assumption of risk and the physician's negligence if the defendant had focused on the refusal that occurred after the operation and had argued application of the common-law doctrine of "avoidable consequences." If the Shorters' failure to mitigate their damages was reasonable, the plaintiff should have suffered no reduction in damages. The evidence, however, clearly established that the Shorters' failure was unreasonable. Therefore, Mr. Shorter should have had his recovery reduced by the amount of damages flowing from his failure to mitigate.

The Shorters clearly had an opportunity to minimize their losses. Both Mr. and Mrs. Shorter were in a position to authorize a blood transfusion subsequent to the negligent performance of the operation. Both knew that death was probably imminent without a transfusion and that a transfusion probably would save Mrs. Shorter's life. Given the gravity of Mrs. Shorter's condition, the refusal clearly was unreasonable. The fact that it was

153. See id. at 660, 695 P.2d at 124 (Pearson, J., dissenting).
154. See supra note 85.
155. Id.
156. Shorter, 103 Wash. 2d at 659, 695 P.2d at 124; see supra notes 105-07 and accompanying text.
158. See supra note 74 and accompanying text.
159. See infra notes 161-65 and accompanying text.
160. See supra note 72 and accompanying text.
161. Shorter, 103 Wash. 2d at 649, 695 P.2d at 119.
162. Id.
163. Id.
based on the Shorters’ religious convictions\(^\text{164}\) did not make the refusal any more reasonable. The Shorters had no right to impose liability on a third party, the defendant, because of their religious beliefs.\(^\text{165}\) Therefore, the Shorters’ refusal to authorize a blood transfusion clearly constituted an unreasonable failure to mitigate damages.

Since Mrs. Shorter probably would have survived if either she or her husband had authorized a transfusion,\(^\text{166}\) the plaintiff, Mr. Shorter, should have been held liable for the consequences flowing from his failure to mitigate,\(^\text{167}\) namely, his wife’s death. If a transfusion had been authorized, and if Mrs. Shorter had therefore survived, Mr. Shorter would not have had an actionable claim for damages under Washington’s wrongful death statute.\(^\text{168}\) Instead, Mrs. Shorter would have had a simple claim of negligence.\(^\text{169}\)

The application of the mitigation doctrine may appear harsh in this context. However, application of the doctrine here would lead to a more equitable result, a result which would recognize that the defendant was helpless to save the patient’s life because of the Shorters’ failure to authorize a blood transfusion. Assessment of liability to the Shorters for failing to mitigate would preclude Mr. Shorter from benefiting from the state of helplessness that he helped to create.

V. **Shorter’s Impact on Litigation and the Resolution of Ethical Dilemmas**

Although the Shorter court failed to assess properly the parties’ respective liabilities, the court’s recognition of the validity of a refusal should have considerable impact in jurisdictions where express assumption of risk has survived comparative fault.\(^\text{170}\) Legislatures should enact statutes recognizing and authorizing the use of valid refusal forms by medical practitioners. Statutory codification of the effect of a refusal to permit treatment will provide clearer guidance to the courts and will reduce medical malpractice litigation.\(^\text{171}\) Moreover, a legally sufficient refusal will give physicians a viable and ethical alternative to seeking court-authorized

\(^{164}\) Id.

\(^{165}\) See supra note 76 and accompanying text.

\(^{166}\) See supra note 72 and accompanying text.

\(^{167}\) See supra note 72 and accompanying text.

\(^{168}\) See supra notes 28-32 and accompanying text.

\(^{169}\) See infra notes 173-82 and accompanying text.
Finally, specific statutory recognition that a valid refusal constitutes an express assumption of the risks flowing from the refusal will result in a more equitable apportionment of damages between the physician and the refusing patient.

A. A Potential Decrease in Litigation

Statutes codifying the availability of a refusal as a damage-reducing defense will provide the courts with clear guidance in cases in which patient refusals prevent physicians from minimizing the effects of their own negligence. Such statutes should provide that while physicians cannot be released from the consequences of their negligence, a refusal to permit treatment will constitute express assumption of the risks resulting from the patient’s failure to mitigate his damages. The patient will thus be liable for that percentage of damages attributable to the failure to permit damage-reducing treatment.

The availability of a refusal as a manifestation of express assumption of risk will serve judicial economy by precluding the filing of suits in which the plaintiff alleges the deprivation of constitutional rights to free exercise of religion or bodily privacy. The refusal will permit medical professionals to respect the patient’s objections instead of administering the undesired treatment and exposing themselves to a lawsuit. Physicians will no longer feel obligated to seek court orders to administer unwanted treatments.

Moreover, recognition of the refusal as a damage-reducing factor will discourage the filing of medical malpractice suits in some comparative negligence jurisdictions. The Shorter decision arose in a jurisdiction which had adopted the “pure” form of comparative negligence. In that case, the jury apportioned seventy-five percent of the fault to the Shorters because they had assumed the risk of Mrs. Shorter’s death. Consideration of the couple’s failure to mitigate might even have increased the percentage. In some jurisdictions, a plaintiff whose fault was found to be so much greater

172. See infra notes 183-90 and accompanying text.
173. See supra notes 63-64 and accompanying text.
174. See supra notes 67-72 and accompanying text.
175. See supra note 60 and accompanying text.
176. See supra note 59 and accompanying text.
177. See supra note 24.
178. Shorter, 103 Wash. 2d at 647, 695 P.2d at 118.
179. See supra notes 157-69 and accompanying text.
than the defendant's would recover nothing.\footnote{180} In such jurisdictions, potential litigants who have refused treatment will be less likely to file suit in view of the probable unfavorable outcome.\footnote{181} Astute plaintiffs' attorneys will attempt to settle out of court in these jurisdictions, hoping that their clients will be at least minimally compensated.\footnote{182} Even plaintiffs in "pure" comparative negligence jurisdictions will settle more readily if they anticipate that out-of-court settlement will lead to a larger recovery by avoiding a jury's somewhat subjective assessment of fault.

\section*{B. Ethical Considerations}

A physician's concerns go beyond those of legal liability; he also must be concerned with the ethics of his profession.\footnote{183} For example, in a non-emergency situation, a physician is faced with three alternatives when a patient refuses to authorize a particular treatment or procedure: he may (1) inform the patient that he cannot treat him and recommend another physician; (2) perform strictly in accordance with the patient's wishes; or (3) accept the patient's refusal, but remain prepared to perform the unauthorized treatment if an emergency occurs.\footnote{184} A doctor should neither have to insist that a competent adult patient submit to the proposed treatment nor have to force the treatment upon the patient against the patient's will.\footnote{185}

The legally sufficient refusal protects the integrity of the hospital as a "helping" institution and of the physician as a professional.\footnote{186} The ethical conflict created by the patient's refusal is eliminated by the additional legal recognition, in the form of the refusal, of the patient's right to self-determination.\footnote{187} The patient's signed refusal to authorize a particular procedure, when properly drafted, relieves the hospital and physician from liability\footnote{188} and represents

\footnote{180. See supra notes 25-27 and accompanying text.}
\footnote{182. See P. Danzon & L. Lillard, The Resolution of Medical Malpractice Claims (1982) (empirical analysis of the disposition of litigated claims).}
\footnote{183. See, e.g., American Medical Ass'n, Principles of Medical Ethics (1982).}
\footnote{184. See Appellant's Motion for Reconsideration and Statement of Additional Authorities at 19, Shorter v. Drury, 103 Wash. 2d 645, 695 P.2d 116 (1985).}
\footnote{186. See United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965).}
\footnote{187. See Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 739-40, 370 N.E.2d 417, 426-27 (1977); see also supra note 51.}
\footnote{188. See supra note 61.}
the profession's concession to and recognition of the patient's constitutional rights.  

A refusal is even possible in emergency situations in which the patient himself is incapable of consenting to an express assumption of a specific risk. A guardian or spouse, as the party most likely to be aware of the patient's religious beliefs or concerns about bodily privacy, can refuse the particular treatment on the patient's behalf. The refusal will allow the professionals to administer only authorized emergency care, thus avoiding potential liability for performing in direct contravention of the patient's wishes.

VI. CONCLUSION

A documented refusal is a viable means of reducing a plaintiff's recovery in a comparative negligence jurisdiction. A valid refusal, that is, one in accord with public policy, sufficiently manifests express assumption of risk, which can be considered as a type of fault in the apportionment of liability. The refusal form should delineate exactly what risks the patient has assumed and should state that medical professionals are not relieved of liability for the consequences of any negligent conduct. At trial, the defendant-physician should argue the patient's duty to mitigate damages: if damages are to be equitably apportioned, the patient must be held accountable for his refusal to permit treatment that would have minimized his losses. The mitigation argument is imperative to the physician's defense since public policy precludes a finding that the patient assumed any risk of the physician's negligence.

The Shorter decision illustrates that a valid refusal can play an important role in a medical malpractice case. The court recognized that medical professionals need an affirmative defense when patients are injured by their own refusals to accept treatment. The survival of express assumption of risk allows use of the refusal as a damage-reducing factor in comparative negligence jurisdictions. As a result, the medical community should, by using this defense, be able to achieve a major reduction in professional liability as damages are more equitably apportioned in refusal cases. At the

189. See supra notes 50-51 and accompanying text.
same time, hospitals and physicians will be able to rely on valid refusal forms to resolve the ethical dilemma created when a patient refuses necessary treatment.

ALISA BETH ARNOFF