Medical Negligence

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I. INTRODUCTION

Pedro Solis, a renowned expert in Legal Medicine in the Philippines, defined "medical jurisprudence" as the legal aspect of medical practice,[1] or the

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Cite as 61 ATENEO L.J. 997 (2017).

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application of legal knowledge to the medical field. One of the important aspects of medical jurisprudence is the medical liability system, which provides for the compensatory and corrective mechanisms for negligence or professional malpractice, and the regulatory framework for the practice of medicine. This means that physicians, in practicing their professions, are subject to strict regulation under which they may be subject to administrative, civil, and criminal liabilities. Hospitals also face liabilities for violation of laws and regulations,[2] including possible civil liability for injuries suffered by patients in the healthcare facility.[3] There are also laws that specifically prescribe the criminal liability of hospitals, wherein the penalty is imposed on its officers or employees.[4] While there are no laws directly addressing medical negligence, existing laws provide a means of enforcing accountability.

The rights and obligations of physicians, and the law that governs the relationship between doctors and patients, are embodied in the Medical Act

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1. PEDRO P. SOLIS, MEDICAL JURISPRUDENCE 1 (1988).

2. *See generally* An Act Requiring the Licensure of all Hospitals in the Philippines and Authorizing the Bureau of Medical Services to Serve as the Licensing Agency [Hospital Licensure Act], Republic Act No. 4226 (1965); An Act Requiring Government and Private Hospitals and Clinics to Extend Medical Assistance in Emergency Cases, Republic Act No. 6615 (1972); An Act Penalizing the Refusal of Hospitals and Medical Clinics to Administer Appropriate Initial Medical Treatment and Support in Emergency or Serious Cases, Amending for the Purpose Batas Pambansa Bilang 702, Otherwise Known as "An Act Prohibiting the Demand of Deposits or Advance Payments for the Confinement or Treatment of Patients in Hospitals and Medical Clinics in Certain Cases", Republic Act No. 8344 (1997); & An Act Prohibiting the Detention of Patients in Hospitals and Medical Clinics on Grounds of Nonpayment of Hospital Bills or Medical Expenses, Republic Act No. 9439 (2007).

3. Civil liability for hospitals may be brought under Article 2176 of the Civil Code, based on a violation of law or the doctrine of corporate negligence. It may also be brought under Article 2180 in relation to Article 2176 of the Civil Code, for negligent acts of its employees. For negligent acts of independent contractors, the Court has also used the doctrine of apparent authority or agency by estoppel. An Act to Ordain and Institute the Civil Code of the Philippines [CIVIL CODE], Republic Act No. 386, arts. 2176 & 2180 (1950).

4. Republic Act No. 6615, § 15; Republic Act No. 8344, § 2; & Republic Act No. 9439, § 3.

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of 1959 (Medical Act).[5] The law provides for the standardization and regulation of medical education; the examination for registration of physicians; and the supervision, control, and regulation of the practice of medicine in the Philippines.[6] Under the Medical Act, gross negligence, ignorance, or incompetence in the practice of medicine resulting in an injury to or death of the patient shall be sufficient ground to suspend or revoke the certificate of registration of any physician.[7]

The Medical Act, however, does not impose any civil or criminal penalty for acts constituting gross negligence, ignorance, or incompetence.[8] These acts are usually prosecuted under Article 365 of the Revised Penal Code,[9] where physicians may be held criminally liable for acts or omissions constituting negligence.[10] While medical negligence may be a criminal offense, there are, in addition, other criminal acts that may be committed specifically by physicians under existing laws.[11]

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5. The Medical Act of 1959, Republic Act No. 2382 (1959) [hereinafter The Medical Act]. *See also* Ivy D. Patdu, Hospital Liability, at 63 (2009) (unpublished J.D. thesis, Ateneo de Manila University) (on file with the Professional Schools Library, Ateneo de Manila University) (citing The Medical Act & An Act to Amend Certain Sections of Republic Act Numbered Twenty-Three Hundred and Eighty-Two, Otherwise Known as "The Medical Act of 1959," Republic Act No. 4224 (1965). Republic Act No. 4224 amended Sections 3 to 7, 9-16, and 18- 21 of the Medical Act of 1959. Republic Act No. 4224, § 1.
6. The Medical Act, § 1.
7. *Id.* § 24 (5).
8. There is only administrative liability for gross negligence, ignorance, or incompetence. *See generally* The Medical Act.
9. An Act Revising the Penal Code and Other Penal Laws [REVISED PENAL CODE], Act No. 3815 (1930).
10. *Id.* art. 365.
11. *See, e.g.*, REVISED PENAL CODE, arts. 174, 259, 347, & 365. Moreover, under Article 15 of the Revised Penal Code, the degree of instruction and education of the offender shall be considered as an alternative circumstance which must be taken into consideration as aggravating or mitigating according to the nature and effects of the crime and the other conditions attending its commission. *Id.* art. 15. *See also* Carl A. T. Antonio, et al., Health Information Privacy in the Philippines: Trends and Challenges in Policy and Practice (An Article Contributed to Privacy in the Developing World — Philippines Monograph Series), *available at* https://www.academia.edu/4727321/Health_information_

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Medical negligence may also be the basis for an award of damages under the Civil Code of the Philippines.[12] The civil liability of physicians may be established on the basis of provisions of the Civil Code but it is often brought as an action based on quasi-delict.[13]

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privacy_in_the_Philippines_Trends_and_challenges_in_policy_and_practice (last accessed May 12, 2017).

Breach of patient privacy in handling health information may also be a ground for criminal liability under Republic Act No. 8504 (handling of information, both the identity and status, concerning persons with human immunodeficiency virus (HIV)), Republic Act No. 9165 (confidentiality of records of those who have undergone rehabilitation), and Republic Act No. 9262 (confidentiality of records pertaining to cases of violence against women and their children), all of which clearly cater to specific populations of patients who may come under the care of health providers. *See* An Act Promulgating Policies and Prescribing Measures for the Prevention and Control of HIV/AIDS in the Philippines, Instituting a Nationwide HIV/AIDS Information and Educational Program, Establishing a Comprehensive HIV/AIDS Monitoring System, Strengthening the Philippine National Aids Council, and for Other Purposes [Philippine AIDS Prevention and Control Act of 1998], §§ 30-33 (1998); An Act Instituting the Comprehensive Dangerous Drugs Act of 2002, Repealing Republic Act No. 6425, Otherwise Known as the Dangerous Drugs Act of 1972, as Amended, Providing Funds Therefor, and for Other Purposes [Comprehensive Dangerous Drugs Act of 2002], § 72 (2002); & An Act Refining Violence Against Women and Their Children, Providing for Protective Measures for Victims, Prescribing Penalties Therefore, and for Other Purposes [Anti-Violence Against Women and Their Children Act of 2004], Republic Act No. 9262, § 44 (2004).

12. An Act to Ordain and Institute the Civil Code of the Philippines [CIVIL CODE], Republic Act No. 386 (1950).

13. CIVIL CODE, arts. 19-21 & 2176. The relevant articles of the Civil Code provide —

> Art. 19. Every person must, in the exercise of his rights and in the performance of his duties, act with justice, give everyone his due, and observe honesty and good faith.
>
> Art. 20. Every person who, contrary to law, wilfully or negligently causes damage to another, shall indemnify the latter for the same.
>
> Art. 21. Any person who wilfully causes loss or injury to another in a manner that is contrary to morals, good customs[,] or public policy shall compensate the latter for the damage.
>
> Art. 2176. Whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done.

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In the past decade, the Supreme Court had the opportunity to decide on several cases involving medical negligence — enriching jurisprudence and providing guidance on the system of medical liability in the country. These developments are included in the succeeding Sections, focusing primarily on medical negligence and physician liability. This Article also briefly considers the impact of the medical liability system in the context of patient safety.

II. PHYSICIAN LIABILITY

A. Administrative Liability

Under the Medical Act, the grounds for reprimand, suspension, or revocation of license to practice medicine are the following:

> (1) Conviction by a court of competent jurisdiction of any criminal offense involving moral turpitude;
>
> (2) Immoral or dishonorable conduct;
>
> (3) Insanity;
>
> (4) Fraud in the acquisition of the certificate of registration;
>
> (5) Gross negligence, ignorance[,] or incompetence in the practice of his or her profession resulting in an injury to or death of the patient;
>
> (6) Addiction to alcoholic beverages or to any habit-forming drug rendering him or her incompetent to practice his or her profession, or to any form of gambling;
>
> (7) False or extravagant or unethical advertisements wherein other things than his [or her] name, profession, limitation of practice, clinic hours, [and] office and home address, are mentioned[;]
>
> (8) Performance of or aiding in any criminal abortion;
>
> (9) Knowingly issuing any false medical certificate;
>
> (10) Issuing any statement or spreading any news or rumor which is derogatory to the character and reputation of another physician without justifiable motive;

> Such fault or negligence, if there is no pre-existing contractual relation between the parties, is called a quasi-delict and is governed by the provisions of this Chapter.

Id.

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(11) Aiding or acting as a dummy of an unqualified or unregistered person to practice medicine; [and]

(12) Violation of any provision of the Code of Ethics as approved by the Philippine Medical Association [[(PMA)].

Refusal of a physician to attend a patient in danger of death is not a sufficient ground for revocation or suspension of his registration certificate if there is a risk to the physician's life.[14]

Where the administrative penalty imposed on a physician is revocation of his or her license, reinstatement is possible after two years if the physician has acted in an exemplary manner in the community wherein he or she resides and has not committed any illegal, immoral, or dishonorable act.[15]

The grounds provided for in the Medical Act are the bases for administrative cases against physicians, which are filed in the Professional Regulatory Commission. Some of these acts or omissions constitute criminal offenses under existing laws,[16] and may be the basis of a criminal complaint against a physician, to be heard in regular courts. The filing of an administrative case does not preclude the filing of a criminal complaint nor an independent civil action for damages. In cases of medical negligence, for example, where a patient dies or is injured, a physician may be administratively liable under the Medical Act when there is gross negligence, ignorance, or incompetence in the practice of his or her profession.[17] The same negligent act may also be the basis for holding a physician criminally liable under Article 365 of the Revised Penal Code[18] or civilly liable for damages under Article 2176 of the Civil Code.[19]

One of the grounds in the Medical Act for the reprimand of a physician, or the suspension or revocation of a physician's license to practice medicine is "[i]mmoral or dishonorable conduct."[20] In a case decided by the Court of

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14. The Medical Act, § 24.

15. *Id.* § 27.

16. *Id.* § 24 (4), (5), (8), (9), (10), & (11).

17. *Id.* § 24 (5).

18. REVISED PENAL CODE, art. 365.

19. CIVIL CODE, art. 2176.

20. The Medical Act, § 24 (2) & Kho, Jr. v. Halili, CA-G.R. S.P. No. 121130 (2012), *available at* http://ca.judiciary.gov.ph/cardis/SP121130.pdf (last accessed May 12, 2017) (unreported) (citing 61 AM. JUR. 2d *Physicians, Surgeons & Other Healers* § 67 (1962)).

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Appeals in 2012, it has been explained that it is not required under the law that "the complained immorality and dishonorable conduct must bear connection with the practice of medicine."[21] In this case, which involved the recording by a physician of a sexual act with a former patient without the latter's consent,[22] the Court of Appeals ruled that the acts constitute an immoral and dishonorable conduct which is a ground for the revocation of the physician's license to practice medicine.[23] The decision explained that the

> relation between the complained act constituting immorality to the practice of medicine need not exist. It may pertain to life in general as there can be no dichotomy to separate a physician's existence into his [or her] professional and personal being. Truly, the standard of morality to which medical practitioners ought to adhere to is quite high, and with good reason.[24]

It must also be noted that one of the grounds enumerated in Section 24 of the Medical Act is the "violation of any provision of the Code of Ethics as approved by the [PMA]."[25] This means that any unethical practice or unprofessional conduct covered by the Code of Ethics, while not expressly provided under Section 24, shall be a ground for reprimand, suspension, or revocation of license to practice medicine.[26] For example, a violation of patient privacy, while not one of the grounds enumerated in the Medical Act, is a violation of the Code of Ethics approved by the PMA,[27] and thus may be a ground for administrative liability of physicians. In 2008, violation of doctor-patient confidentiality was one of the issues raised against health personnel charged with grave misconduct, gross neglect of duty, or conduct

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21. *Kho, Jr.*, CA-G.R. S.P. No. 121130 (unreported).
22. *Id.*
23. *Id.*
24. *Id.*
25. The Medical Act, § 24 (12).
26. Philippine Medical Association, PMA Code of Ethics, Implementing Guidelines, at 1, *available at* https://www.philippinemedicalassociation.org/downloads/pma-codes/IRR%20of%20the%20Code%20of%20Ethics.pdf (last accessed May 12, 2017).
27. Philippine Medical Association, Code of Ethics of the Philippine Medical Association, art. II, § 6, *available at* https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf (last accessed May 12, 2017).

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prejudicial to the best interest of service in relation to the video recording of a sensitive procedure performed on a patient in a hospital operation room, and later uploaded in YouTube.[28]

In addition to the Medical Act, another law that imposes administrative liability on physicians is Executive Order (E.O.) No. 212,[29] requiring the attending physician who treats a person for serious or less serious physical injuries to report the fact of such treatment promptly to the nearest government health authority.[30] Under E.O. No. 212, failure to comply with the reporting requirement may subject a physician to administrative liability, and upon the third violation, shall also cause the cancellation of his or her license.[31] This law was invoked by the Philippine National Police in 2015 when administrative cases were filed against physicians of a private hospital who allegedly refused to provide information on the admission of a patient with a serious physical injury.[32] The incident revealed gaps in the implementation of the law. At that time, there was no reporting being made on cases of serious or less serious physical injury to the "nearest government health authority." In practice, these cases were being recorded at the emergency room, and often reported to the police.[33] While the Department of Health (DOH) has not issued rules and regulations necessary to carry out the purposes of the E.O.; it must be noted, however, that the DOH collects

28. GMA News Online, Cebu surgery scandal: Findings anger victim of abuse, *available at* http://www.gmanetwork.com/news/story/90323/news/regions/cebu-surgery-scandal-findings-anger-victim-of-abuse (last accessed May 12, 2017). *See* Antonio, et al., *supra* note 11.

29. Office of the President, Amending Presidential Decree No. 169, Executive Order No. 212, Series of 1987 [E.O. No. 212, s. 1987], § 1 (July 10, 1987).

30. *Id.* § 1.

31. *Id.*

32. Julliane Love De Jesus, *PNP to file raps vs Asian Hospital, Ayala Alabang security officers*, PHIL. DAILY INQ., May 12, 2015, *available at* http://www.newsinfo.inquirer.net/690826/pnp-to-file-raps-vs-ahmc-ayala-alabang-village-security-officers (last accessed May 12, 2017).

33. This is based on inquiries made with the Department of Health (DOH) and with several hospitals in Metro Manila.

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health information on patient injury under the Online National Electronic Injury Surveillance System.[34]

B. Criminal Liability

Criminal liability for medical negligence is usually brought as an action under Article 365 of the Revised Penal Code providing for criminal imprudence and negligence.[35] In the case of *Ang v. Grageda*,[36] for example, the physician was charged with reckless imprudence resulting to homicide after his patient died during a liposuction surgery.[37] The elements of reckless imprudence are:

> (1) that the offender does or fails to do an act;
>
> (2) that the doing or the failure to do that act is voluntary;
>
> (3) that it be without malice;
>
> (4) that material damage results from the reckless imprudence; and
>
> (5) that there is *inexcusable lack of precaution* on the part of the offender, taking into consideration his [or her] employment or occupation, degree of intelligence, physical condition, and other circumstances regarding persons, time[,] and place.[38]

The meaning of "inexcusable lack of precaution" has been defined as

> whether or not a physician has committed an 'inexcusable lack of precaution' in the treatment of his [or her] patient is to be determined according to the standard of care observed by other members of the profession in good standing under similar circumstances bearing in mind

34. Department of Health, Revised National Policy on Violence and Injury Prevention, Administrative Order No. 2, Series of 2014 [A.O. No. 2014-0002] (Jan. 20, 2014).

35. REVISED PENAL CODE, art. 365. *See also* REVISED PENAL CODE, arts. 174 & 259.

36. Ang v. Grageda, 490 SCRA 424 (2006).

37. *Id.* at 428. *See also* Cabugao v. People, 731 SCRA 214 (2014); Jarcia, Jr. v. People, 666 SCRA 336 (2012); & Cruz v. Court of Appeals, 282 SCRA 188 (1997).

38. *Cruz*, 282 SCRA at 199-200 (emphasis supplied).

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> the advanced state of the profession at the time of treatment or the present state of medical science.[39]

In cases where the negligence is not of a reckless nature — which is when the lack of precaution occurs in cases where the damage to be caused is not immediate or the danger is not clearly manifest — the criminal offense may be that of simple imprudence.[40] The elements of simple imprudence are as follows:

(1) that there is lack of precaution on the part of the offender; and

(2) that the damage impending to be caused is not immediate or the danger is not clearly manifest.[41]

In defining "inexcusable lack of precaution" in a case of criminal negligence, the Court referred to a "standard of care" upon which a finding of liability on the part of the physician is evaluated.[42] This standard does not change, whether the case is criminal or civil in nature. In cases involving negligence, the standard upon which a physician's act or omission is evaluated is separate from the evaluation of whether the weight of evidence meets the burden of proof.

The provisions of criminal negligence will also be applicable even if the individual practicing medicine does not have a valid license. In an old case decided by the Court, the accused was not licensed to practice medicine but undertook to treat a patient suffering from a body ailment —

> The allegations in the information in this case that the accused acted with reckless negligence in diagnosing, prescribing for, and treating the deceased [ ], knowing that she did not possess the necessary technical knowledge or skill to do so, thus causing her death, sufficiently charge the crime of homicide through reckless imprudence, since ordinary diligence counsels one not to tamper with human life by trying to treat a sick man when he knows that he does not have the special skill, knowledge, and competence to attempt such treatment and cure, and may consequently reasonably foresee harm or injury to the latter. In a similar case wherein the accused, not being a regular practitioner, undertook to render medical assistance to

39. *Id.* at 200 (citing AMADO S. TOLENTINO, JR., MEDICINE AND LAW: PROCEEDINGS OF THE SYMPOSIUM ON CURRENT ISSUES COMMON TO MEDICINE AND LAW 24 (1980)).

40. *Jarcia, Jr.*, 666 SCRA at 343-44.

41. *Id.* at 343.

42. *Id.* at 344.

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> another, causing physical injuries to the latter, said accused was found guilty and convicted by this Court of physical injuries through imprudence under the old Penal Code.[43]

It must be clear that when a physician practices medicine without a license, the physician may be made liable for illegal practice of medicine, considered as a crime under the Medical Act.[44] Whether a physician is licensed or not, however, the physician may be criminally liable under the Revised Penal Code for injuries incurred by a patient.

With regard to recent laws, the Data Privacy Act of 2012 (Data Privacy Act)[45] may subject a physician to criminal liability in relation to the processing of personal health information.[46] The Data Privacy Act, while being a law of general application that is intended for the protection of personal data, may impact health professionals because health information being collected and used in a healthcare setting are considered highly sensitive in nature.[47] The law allows the processing of sensitive personal information necessary for purposes of medical treatment, carried out by a medical practitioner or a medical treatment institution, where an adequate level of protection of personal information is ensured.[48] This means that any other use of health information requires consent from the patient.[49] It also obligates the physician collecting, using, or storing health information of patients to assure its confidentiality, and implement safeguards to protect it

43. People v. Vda. de Golez, 108 Phil. 855, 859 (1960) (citing United States v. Divino, 12 Phil. 175, 190-91 (1908)).

44. The Medical Act, §§ 8, 10, & 28. The Medical Act imposes the penalty of imprisonment, fine, or both for any person found guilty of illegal practice of medicine. This refers to the act of engaging in the practice of Medicine (defined in Section 10) without complying with the prerequisites provided by the same act (as provided in Section 8). There is no penalty for gross negligence, ignorance, or incompetence other than administrative liability. *Id.*

45. An Act Protecting Individual Personal Information in Information and Communications System in the Government and the Private Sector, Creating for This Purpose a National Privacy Commission, and for Other Purposes [Data Privacy Act of 2012], Republic Act No. 10173 (2012).

46. *Id.* §§ 25-32.

47. *See* Data Privacy Act of 2012, § 13.

48. *Id.*

49. *Id.*

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from unwarranted disclosures or unauthorized processing.[50] Violation of the Data Privacy Act may correspond to criminal acts, for which the law imposes heavy penalties.[51]

C. Civil Liability

The Court has defined medical negligence as "that type of claim which a victim has available to him or her to redress a wrong committed by a medical professional which has caused bodily harm."[52] Medical negligence cases may be brought as an action for damages under Article 2176 of the Civil Code, or Article 2180 in relation to Article 2176.[53] These cases may proceed independently of administrative or criminal proceedings also based on medical negligence.

Article 2176 imposes obligations based on quasi-delict. There are three basic elements in quasi-delict:

(1) damages suffered by the plaintiff (harm);

(2) fault or negligence of the defendant (wrong); and

(3) the connection of cause and effect between the fault or negligence of the defendant and the damages inflicted on the plaintiff.[54]

Thus, negligence cannot create a right of action unless it can be shown that the fault or negligence is the proximate cause of the damage sustained by the plaintiff.[55] Proximate cause is "that cause which, in natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury, and without which the result would not have occurred."[56]

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50. *Id.* §§ 25 & 29.

51. *Id.* §§ 25-37.

52. Garcia-Rueda v. Pascasio, 278 SCRA 769, 778 (1997).

53. *See* CIVIL CODE, art. 2176 & 2180.

54. Taylor v. Manila Electric Railroad and Light Co., 16 Phil. 8, 15 (1910).

55. *Cruz*, 282 SCRA at 202 (citing Chan Lugay v. St. Luke's Hospital, Inc., 10 CA Reports 415, 427-28 (1966)).

56. Ramos v. C.O.L. Realty Corporation, 597 SCRA 526, 535 (2009). *See also* Vda. de Bataclán, et al. v. Medina, 102 Phil. 181, 186 (1957).

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Article 2176, on one hand, presupposes that there is no pre-existing contractual relation between doctor and physician.[57] If there is a definite contract between physician and patient, an action based on breach of contract, or failure to fulfill a contractual obligation, may also be instituted.[58] In most cases, however, the contract between physician and patient does not include obligations to deliver a definite outcome or cure. The Court already had occasion to rule that the existence of a contract does not bar the commission of a tort, and civil cases based on quasi-delict may still be filed.[59]

Article 2180, on the other hand, provides the basis for vicarious liability of physicians.[60] The obligations imposed by Article 2176 are demandable not only for one's own acts or omissions, but also for the acts of persons for whom one is responsible.[61] In medical negligence cases, the Captain of the Ship doctrine has been applied to make a physician, usually a surgeon, liable for acts of negligence committed by a nurse or another physician.[62] Article 2180 provides that the responsibility imposed under the said provision shall cease when the persons being made liable for acts of another prove that they observed all the diligence of a good father of a family to prevent damage.[63]

D. Elements of Medical Negligence

In a medical negligence case, the patient or plaintiff has the duty of proving its elements, which corresponds to the elements of quasi-delict, namely:

(1) a *duty* of the defendant to his or her patient;

(2) the defendant's *breach* of this duty;

(3) *injury* to the patient; and

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57. CIVIL CODE, art. 2176.

58. *Id.* art. 1170.

59. Singson v. Bank of the Philippine Islands, 23 SCRA 1117, 1119-20 (1968) & Cangco v. Manila Railroad Co., 38 Phil. 768, 775-76 (1918).

60. CIVIL CODE, art. 2180.

61. *Id.*

62. Mendoza v. Casumpang, 668 SCRA 436, 439 (2012).

63. CIVIL CODE, art. 2180. Article 2180 of the Civil Code has been modified by Article 221 of the Family Code. The Family Code of the Philippines [FAMILY CODE], Executive Order No. 209, art. 221 (1987).

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(4) *proximate causation* between the breach and the injury suffered.[64]

The test to determine negligence is whether the defendant, in doing the alleged negligent act, uses that reasonable care and caution which an ordinarily prudent person would have used in the same situation.[65] If the defendant did not, then he or she committed negligence.[66] Thus, it must be established that the physician has a duty of care to a patient. This duty is founded on the existence of a physician-patient relationship. The physician must have breached this duty of care, either failing to do something that a reasonably prudent physician would have done, or performing an act that should not have been done based on the same standard.[67] When the breach of duty consists of acts or omissions established to be the proximate cause of an injury to or death of a patient, then the physician may be held accountable for medical negligence.

An important element of medical negligence is the duty of a physician to a patient.[68] It is important to determine when the doctor-patient relationship is established because it is at this point that the physician becomes obliged to perform his or her duties. The relationship between doctor and patient begins when the patient engages the services of a physician, and the physician accepts a case —

> When a patient engages the services of a physician, a physician-patient relationship is generated. And in accepting a case, the physician, for all intents and purposes, represents that he [or she] has the needed training and skill possessed by physicians and surgeons practicing in the same field; and that he [or she] will employ such training, care, and skill in the treatment of the patient. Thus, in treating his [or her] patient, a physician is under a *duty* to [the former] to exercise that degree of care, skill[,] and diligence which physicians in the same general neighborhood and in the same general line of practice ordinarily possess and exercise in like cases. Stated otherwise, the physician has the obligation to use at least the same level of care that any

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64. Borromeo v. Family Care Hospital, Inc., 781 SCRA 527, 539 (citing *Garcia-Rueda*, 278 SCRA at 778; Flores v. Pineda, 571 SCRA 83, 91 (2008); & Reyes v. Sisters of Mercy Hospital, 341 SCRA 760, 769 (2000)).
65. Picart v. Smith, 37 Phil. 809, 813 (1918).
66. *Id.*
67. Li v. Soliman, 651 SCRA 32, 55 (2011).
68. Lucas v. Tuaño, 586 SCRA 173, 200 (2009).

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> other reasonably competent physician would use to treat the condition under similar circumstances.[69]

The duty to a patient means that the physician must meet the standard of care in treating and managing his or her patient.[70] This standard of care is evaluated based on the degree of skill, knowledge, and training ordinarily expected of other reasonably competent members of the profession practicing in the same field of medicine, acting under the same circumstances.[71] It has been clarified that "[a] doctor's duty to his [or her] patient is not required to be extraordinary. The standard contemplated for doctors is simply the reasonable average merit among ordinarily good physicians, [i.e.], reasonable skill and competence."[72]

An inquiry into the standard of care is required in order to determine whether a physician has breached his or her duty to the patient.[73] Failure to meet the standard of care constitutes breach of duty.[74] This breach should result in an injury to or death of a patient to be actionable.[75] A bad outcome by itself is insufficient to establish negligence. As the Supreme Court clarified in a case, "[d]octors are protected by a special law. They are not guarantors of care. They do not even warrant a good result. They are not insurers against mishap or unusual consequences. Furthermore, they are not liable for honest mistake of judgment[.]"[76]

Thus, for purposes of awarding damages, it must be shown that the breach of duty is the proximate cause of injury to or death of a patient —

> The breach of these professional duties of skill and care, or their improper performance by a physician surgeon, whereby the patient is injured in body or in health, constitutes actionable malpractice. As to this aspect of medical malpractice, the determination of the reasonable level of care and the breach thereof, expert testimony is essential. Further, inasmuch as the

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69. *Lucas*, 586 SCRA at 200 (citing *Garcia-Rueda*, 278 SCRA at 778 & Snyder v. Pantaleo, 143 Conn. 290, 292 (1956) (U.S.)).

70. *Lucas*, 586 SCRA at 200-01.

71. *Id.*

72. Bondoc v. Mantala, 740 SCRA 311, 327 (2014) (citing Ruñez, Jr. v. Jurado, 477 SCRA 1, 7 (2005)).

73. *Lucas*, 586 SCRA at 200-01.

74. *Id.*

75. *Id.*

76. *Cruz*, 282 SCRA at 192 (citing TOLENTINO, *supra* note 39).

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causes of the injuries involved in malpractice actions are determinable only in the light of scientific knowledge, it has been recognized that expert testimony is usually necessary to support the conclusion as to causation.[77]

In cases where evidence shows that the proximate cause of the injury is the patient's own negligence, the physician will not be liable for damages. In *Cayao-Lasam v. Ramolete*,[78] for example, the Court ruled against the patient because it found that the patient omitted the diligence required by the circumstances while the physician observed standard medical practice.[79] In this case, the patient underwent a procedure and was asked to come back for a follow-up evaluation by the physician.[80] The patient suffered a complication but the Court surmised that her failure to return prevented the physician from conducting proper medical tests and applying appropriate treatment.[81] The failure to return by the patient was considered by the Court as the proximate cause of her own injury, precluding an award of damages[82] —

> Difficulty seems to be apprehended in deciding which acts of the injured party shall be considered [as] immediate causes of the accident. Where the immediate cause of an accident resulting in an injury is the plaintiff's own act, which contributed to the principal occurrence as one of its determining factors, he [or she] cannot recover damages for the injury. Again, based on the evidence presented in the present case under review, in which no negligence can be attributed to the petitioner, the immediate cause of the accident resulting in Editha's injury was her own omission when she did not return for a follow-up check-up, in defiance of petitioner's orders. The immediate cause of Editha's injury was her own act; thus, she cannot recover damages from the injury.[83]

The importance of establishing proximate cause must be emphasized. Even in cases of medical negligence for purposes of establishing criminal

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77. Cayao-Lasam v. Ramolete, 574 SCRA 439, 454-55 (2008) (citing *Garcia-Rueda*, 278 SCRA at 778-79; *Reyes*, 341 SCRA at 769; & *Cruz*, 282 SCRA at 200).
78. Cayao-Lasam v. Ramolete, 574 SCRA 439 (2008).
79. *Id.* at 459-60.
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.* at 460 (citing *Taylor*, 16 Phil. at 26-27) (emphasis omitted).

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liability under the Revised Penal Code, the element of causation must be shown.[84]

In general, medical negligence requires evidence of the following —

> Essentially, it requires two-pronged evidence: evidence as to the recognized standards of the medical community in the particular kind of case, and a showing that the physician in question negligently departed from this standard in his [or her] treatment.
>
> Another element in medical negligence cases is causation[,] which is divided into two inquiries: whether the doctor's actions in fact caused the harm to the patient and whether these were the proximate cause of the patient's injury.[85]

III. RECENT CASES ON MEDICAL NEGLIGENCE

A. Causation and Expert Testimony

Cases recently decided by the Supreme Court reiterate the importance of proximate cause in establishing medical negligence. In these cases, the Supreme Court also discussed the importance of the expert witness in establishing standard of care, injury, and the causal connection between breach of duty and injury. To be considered an expert witness, the expertise must be demonstrated through possession of knowledge, skill, experience, or training on the particular medical specialty and practice relevant to the treatment of the patient's condition.[86]

In the case of *Cereno v. Court of Appeals*,[87] the Supreme Court ruled that causation was not proven, and thus, negligence was not established.[88] This case involved a victim of a stabbing incident, brought to the emergency room of a hospital.[89] The patient was scheduled for surgery but was not immediately operated on because many other patients required emergency care.[90] The surgeons first operated on a gunshot wound victim, and

84. *See Jarcia, Jr.*, 666 SCRA at 357.

85. *Garcia-Rueda*, 278 SCRA at 779 (citing Davis v. Virginian R. Co., 361 U.S. 354, 357 (1960)).

86. Casumpang v. Cortejo, 752 SCRA 379, 421 (2015).

87. Cereno v. Court of Appeals, 682 SCRA 18 (2012).

88. *Id.* at 33-34.

89. *Id.* at 20-21.

90. *Id.* at 21.

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afterwards, they had to wait for the availability of the only anesthesiologist in the hospital who was attending to a pregnant patient who delivered triplets.[91]

The Court noted that petitioners exerted earnest efforts to save the life of the patient,[92] and ruled that

> [i]n medical negligence cases, it is settled that the complainant has the burden of establishing breach of duty on the part of the doctors or surgeons. It must be proven that such breach of duty has a causal connection to the resulting death of the patient. A verdict in malpractice action cannot be based on speculation or conjecture. Causation must be proven within a reasonable medical probability based upon competent expert testimony.
>
> ...
>
> Their cause stands on the mere assumption that Raymond's life would have been saved had petitioner surgeons immediately operated on him[,] had the blood been cross-matched immediately[,] and had the blood been transfused immediately. There was, however, no proof presented that Raymond's life would have been saved had those things been done. Those are mere assumptions and cannot guarantee their desired result. Such cannot be made basis of a decision in this case, especially considering that the name, reputation[,] and career of petitioners are at stake.[93]

The case of *Cereno* is recognition that in medical negligence cases, the basis of liability is not the happening of a bad outcome per se, but the causal link between the bad outcome and the physician's failure to meet the standard of care.[94]

This is the same principle used in deciding the case of *Dela Torre v. Imbuido*.[95] The case involved a patient who delivered a baby via caesarian section.[96] After the operation the patient's condition worsened, eventually causing her demise.[97] The Supreme Court said that —

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91. *Id.*

92. *Id.* at 34.

93. *Cereno*, 682 SCRA at 33-34 (citing *Cruz*, 282 SCRA at 202).

94. *Id.*

95. Dela Torre v. Imbuido, 736 SCRA 655 (2014).

96. *Id.* at 658.

97. *Id.*

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> [*t*]*he critical and clinching factor in a medical negligence case is proof of the causal connection between the negligence and the injuries.* The claimant must prove not only the injury but also the defendant's fault, and that such fault caused the injury. A verdict in a malpractice action cannot be based on speculation or conjecture. Causation must be proven within a reasonable medical probability based upon competent expert testimony[.][98]

In this case, the cause of death as indicated in the medical certificate was different from the autopsy report of the medico-legal officer, who testified as expert witness.[99] The Court, however, did not automatically accept the report of the medico-legal officer but looked into his qualifications as an expert witness, including his specialization, and whether he was competent to testify on "on the degree of care, skill[,] and diligence needed for the treatment of [the patient's] case."[100] Unable to satisfactorily establish proximate cause, the Court denied the petition.[101]

The qualification of the expert witness was also discussed in *Borromeo v. Family Care Hospital, Inc.*,[102] where the Supreme Court said that medical malpractice cases are highly technical and expert testimony is essential.[103] With regard to the expert witness, the Court explained, "[t]he expert witness must be a similarly trained and experienced physician. Thus, a pulmonologist is not qualified to testify as to the standard of care required of

98. *Id.* at 666 (citing *Flores*, 571 SCRA at 99) (emphasis supplied).

99. *Dela Torre*, 736 SCRA at 658-59.

100. *Id.* at 664.

101. *Id.* at 666.

102. Borromeo v. Family Care Hospital, Inc., 781 SCRA 527 (2016).

103. *Id.* at 540. The Supreme Court said that —

> Because medical malpractice cases are often highly technical, expert testimony is usually essential to establish:
>
> (1) the standard of care that the defendant was bound to observe under the circumstances;
>
> (2) that the defendant's conduct fell below the acceptable standard; and
>
> (3) that the defendant's failure to observe the industry standard caused injury to his patient.

Id.

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an anesthesiologist and an autopsy expert is not qualified to testify as a specialist in infectious diseases."[104]

The recent cases underscore not only how proximate cause is a critical consideration that must be sufficiently demonstrated in establishing elements of medical negligence, but also the importance of showing the qualifications of an expert witness who must be competent to testify on the specific medical issues of the case.

B. Doctrine of Res Ipsa Loquitur

Expert testimony is required to determine whether a particular healthcare provider deviated from a standard of care.[105] By way of exception, the courts sometimes utilize the doctrine of *res ipsa loquitur* to assign liability in cases where the circumstances warrant an inference of negligence even in the absence of specific proof.

Res ipsa loquitur is Latin for "the thing or the transaction speaks for itself," and is recognition that, as a matter of common knowledge and experience, the very nature of some occurrences may justify an inference of negligence on the part of the person who controls the instrumentality causing the injury.[106] The application of this rule requires:

> (1) that the accident was of a kind which does not ordinarily occur unless someone is negligent;
>
> (2) that the instrumentality or agency which caused the injury was under the exclusive control of the person charged with negligence; and
>
> (3) that the injury suffered must not have been due to any voluntary action or contribution from the injured person.[107]

The concurrence of these elements creates a presumption of negligence providing a means to assist the patient in establishing breach of duty and proximate cause even in the absence of expert testimony.[108] The doctrine of *res ipsa loquitur* should be understood as an evidentiary rule —

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104. *Id.* (citing *Cruz*, 282 SCRA at 200-01 & Ramos v. Court of Appeals, 321 SCRA 584, 601-02 (1999)).

105. *Casumpang*, 752 SCRA at 406.

106. *Ramos*, 321 SCRA at 598-99 (citing Africa, et al. v. Caltex (Phil.), Inc., et al., 16 SCRA 448, 454 (1966)).

107. Malaya Insurance Co. v. Alberto, 664 SCRA 791, 803-04 (2012).

108. Batiquin v. Court of Appeals, 258 SCRA 334, 344-45 (1996).

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The doctrine of *res ipsa loquitur* as a rule of evidence is peculiar to the law of negligence which recognizes that prima facie negligence may be established without direct proof and furnishes a substitute for specific proof of negligence. The doctrine is not a rule of substantive law, but merely a mode of proof or a mere procedural convenience. The rule, when applicable to the facts and circumstances of a particular case, is not intended to and does not dispense with the requirement of proof of culpable negligence on the party charged. It merely determines and regulates what shall be prima facie evidence thereof and facilitates the burden of plaintiff of proving a breach of the duty of due care. *The doctrine can be invoked when and only when, under the circumstances involved, direct evidence is absent and not readily available.*[109]

This doctrine was applied in *Ramos v. Court of Appeals*,[110] where the Supreme Court held that a physician was negligent based primarily on the doctrine of *res ipsa loquitur* when a previously healthy and robust patient became comatose following intubation.[111] The same doctrine was used to establish the negligence of the physician in a case where a patient incurred a burn wound on her left arm due to contact with a droplight while in the recovery room,[112] or where a surgeon left a foreign object inside the body of the patient.[113]

It was also recently applied in the case of a patient with a fracture of the mandible or the jaw.[114] The surgeon operated on the patient and applied improper sized screws to fasten a metal plate intended to immobilize the jaw.[115] The patient experienced pain and limited function after the operation, prompting said patient to consult with a dentist who performed another operation which afforded the patient relief.[116] The Court said —

whether the screw hit [the patient's] molar because it was too long or improperly placed, both facts are the product of [the physician's] negligence. An average [person] of common intelligence would know that

109. *Id.* at 340 (citing Layugan v. Intermediate Appellate Court, 167 SCRA 363, 376-77 (1988)) (emphasis supplied).

110. Ramos v. Court of Appeals, 321 SCRA 584 (1999).

111. *Id.* at 617.

112. Cantre v. Go, 522 SCRA 547, 555 (2007).

113. *Batiquin*, 258 SCRA at 345-46 (1996).

114. Rosit v. Davao Doctors Hospital, 776 SCRA 303, 308 (2015).

115. *Id.*

116. *Id.* at 308-09.

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> striking a tooth with any foreign object[,] much less a screw[,] would cause severe pain [without the need of expert witness].[117]

The doctrine of *res ipsa loquitur* should, however, only be applied by way of exception. It is not intended to shift the burden of evidence to the person charged with negligence. By its very nature, the practice of Medicine requires years of training, and is based on gaining scientific and technical knowledge and expertise to adhere to professional standards. The doctrine does not apply to cases where the circumstances do not make the failure to observe due care immediately apparent to a layman, or where the actual cause of the injury had been identified or established.

In *Cruz v. Agas, Jr.*,[118] the Supreme Court rejected the application of the doctrine of *res ipsa loquitur*.[119] In this case, the patient underwent a gastroscopy and colonoscopy procedure.[120] After the procedure, the patient experienced dizziness, collapsed, and, thereafter, had to undergo an emergency surgical operation.[121] Based on evidence, the Court recognized that not every complication arising from a medical procedure is tantamount to negligence, and that the correlation between the injury and the act subject of complaint must be established.[122]

The Court said that the negligence in this case "was not immediately apparent to a layman to justify the application of *res ipsa loquitur* doctrine."[123] The Court relied on the evidence presented by the physician that he did not deviate from any standard medical norm, practice, or procedure and that the complications suffered by the patient was not caused by his negligence or medical malpractice[124] —

> A medical negligence case can prosper if the patient can present solid proof that the doctor, like in this case, either failed to do something which a reasonably prudent doctor would have done, or that he did something that

117. *Id.* at 315.

118. Cruz v. Agas, Jr., 757 SCRA 549 (2015).

119. *Id.* at 557-59.

120. *Id.* at 551-52.

121. *Id.* at 552.

122. *Id.* at 557-58.

123. *Id.* at 558.

124. *Cruz*, 757 SCRA at 558.

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> a reasonably prudent doctor would not have done, and such failure or action caused injury to the patient.[125]

In this case, the Court ruled that the patient failed to demonstrate that there was inexcusable lack of precaution on the part of the physician, and to establish the correlation between his injury and the colonoscopy procedure performed by physician.[126] The Court rejected the application of *res ipsa loquitur* doctrine and considered the presentation of an expert opinion as important in the case.[127]

C. Failure to Timely Diagnose or Intervene

The Supreme Court had the opportunity to evaluate medical negligence cases involving a physician's failure to accurately and timely diagnose a patient's condition, or initiate life-saving measures.

In *Casumpang v. Cortejo*,[128] an 11-year-old boy was brought to a hospital for difficulty in breathing, chest pain, stomach pain, and fever.[129] The patient was admitted to the hospital, where he was initially diagnosed with bronchopneumonia.[130] While admitted, the child vomited blood and had leg pain, prompting additional tests.[131] It was only then that the child was diagnosed with Dengue Hemorrhagic Fever (Dengue fever).[132] The physician recommended admission in the Intensive Care Unit but the family instead decided to transfer the child to another hospital, where the patient eventually died.[133] The patient's family claimed that the failure of the physician to timely diagnose Dengue fever led to the patient's death.[134]

In ruling on the case, the Supreme Court clarified that it was not deciding on the correctness of a physician's diagnosis.[135] Instead, the Court is

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125. *Id.* at 557.
126. *Id.* at 556-57.
127. *Id.* at 557-59.
128. Casumpang v. Cortejo, 752 SCRA 379 (2015).
129. *Id.* at 388-89.
130. *Id.* at 389.
131. *Id.* at 390-92.
132. *Id.* at 392.
133. *Id.*
134. *Casumpang*, 752 SCRA at 392.
135. *Id.* at 412-13.

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evaluating whether the evidence is able to show that the physician observed the standard of care in arriving at his or her diagnosis[136] —

> [M]edicine is not an exact science; and doctors, or even specialists, are not expected to give a 100% accurate diagnosis in treating patients who come to their clinic for consultations. Error is possible as the exercise of judgment is called for in considering and reading the exhibited symptoms[and] the results of tests, and in arriving at definitive conclusions. But in doing all these, the doctor must have acted according to acceptable medical practice standards.[137]

In this case, the Court ruled that the physician was liable for medical negligence for his failure to timely diagnose Dengue fever based on the particular circumstances of the case.[138] The Court ruled that the physician's failure to detect Dengue fever was the result of negligent conduct —

> [During the time of the physician's] first and second visits to [the patient], he already had knowledge of [the patient's] laboratory test result [Complete Blood Count] (CBC), medical history, and symptoms (i.e., fever, rashes, rapid breathing, chest and stomach pain, throat irritation, difficulty in breathing, and traces of blood in the sputum). However, these information did not lead the physician to the possibility that [the] patient could be suffering from either [D]engue fever[ ] as he clung to his diagnosis of bronchopneumonia. This means that given the symptoms exhibited, [the] doctor already ruled out the possibility of other diseases like [D]engue.
>
> ...
>
> [A] wrong diagnosis is not by itself medical malpractice. Physicians are generally not liable for damages resulting from a bona fide error of judgment. Nonetheless, when the physician's erroneous diagnosis was the result of negligent conduct (e.g., neglect of medical history, failure to order the appropriate tests, [or] failure to recognize symptoms), it becomes an evidence of medical malpractice.
>
> ...
>
> In the present case, evidence on record established that in confirming the diagnosis of bronchopneumonia, [the doctor] selectively appreciated some and not all of the symptoms presented, and failed to promptly conduct the appropriate tests to confirm his findings. In sum, [the doctor] failed to timely detect [D]engue fever, which failure, especially when reasonable

136. *Id.*

137. *Id.* at 413.

138. *Id.*

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> prudence would have shown that indications of dengue were evident and/or foreseeable, constitutes negligence.[139]

In the case of *Jarcia, Jr. v. People,*[140] the Supreme Court also ruled on the failure of physicians to timely diagnose a medical condition based on the fact that the patient was not provided an extensive examination at the time of first consult at the emergency room.[141] This was brought as a criminal case for "simple imprudence resulting to serious physical injuries" against the physicians who saw a patient who was hit by a taxicab.[142] The patient was brought to the emergency room where an X-ray of his ankle was taken, which showed that there was no fracture.[143] It was reported that the physicians did not order any other X-ray on the leg because "only the ankle was hit."[144]

Several days later, with the symptoms of the patient worsening, including swelling of his right leg, he was brought back to the hospital where an "X-ray revealed a right mid-tibial fracture and a linear hairline fracture in the shaft of the bone."[145] The fracture of the leg is in the nature of a serious physical injury that was not diagnosed at the time of the first consultation at the emergency room because the focus of management was the victim's ankle, which was not fractured.[146]

The Court explained that the resident physicians did not perform a thorough examination even if they were expected to know the medical protocol in treating leg fractures.[147] It was also noted that even if the resident physicians were incapable of performing a thorough evaluation, the patient should have been referred to the appropriate specialist.[148] The Court, however, said that evidence was insufficient to establish guilt beyond

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139. *Id.* at 408 & 413 (emphases omitted).

140. Jarcia, Jr. v. People, 666 SCRA 336 (2012).

141. *Id.* at 358.

142. *Id.* at 341.

143. *Id.* at 342.

144. *Id.*

145. *Id.*

146. *Jarcia, Jr.*, 666 SCRA at 342.

147. *Id.* at 357.

148. *Id.* at 347.

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reasonable doubt but that the physicians were civilly liable for their failure to sufficiently attend to the medical needs of the patient.[149] The Court ruled —

> There was, however, no precise evidence and scientific explanation pointing to the fact that the delay in the application of the cast to the patient's fractured leg because of failure to immediately diagnose the specific injury of the patient, prolonged the pain of the child or aggravated his condition or even caused further complications. Any person may opine that had [the] patient [ ] been treated properly and given the extensive X-ray examination, the extent and severity of the injury, spiral fracture of the mid-tibial part or the bigger bone of the leg, could have been detected early on and the prolonged pain and suffering [of the patient] could have been prevented. But still, that opinion, even how logical it may seem[,] would not, and could not, be enough basis to hold one criminally liable; thus, a reasonable doubt as to the petitioners' guilt.[150]

In *Cabugao v. People*,[151] the Supreme Court found a surgeon liable for failing to perform the required appendectomy on a 10-year-old boy.[152] The patient in this case was admitted under the care of a family physician, who considered as his initial working impression a diagnosis of acute appendicitis.[153] The said family physician referred the patient to the surgeon who decided to put the patient under 24-hour monitoring.[154] The patient's condition while being monitored worsened until he died the following day.[155] The Court ruled that based on the facts of the case, it was sufficiently established that to prevent certain death, it would have been necessary to perform surgery on the patient[156] —

> From the testimonies of the expert witnesses presented, it was irrefutably proven that [the doctor] failed to practice that degree of skill and care required in the treatment of his patient.
>
> As correctly observed by the appellate court, [the doctor] revealed want of reasonable skill and care in attending to the needs of [the patient] by neglecting to monitor effectively the developments and changes on [the

149. *Id.* at 357-58.

150. *Id.* at 357.

151. Cabugao v. People, 731 SCRA 214 (2014).

152. *Id.* at 218.

153. *Id.* at 220.

154. *Id.*

155. *Id.* at 220-21.

156. *Id.* at 228.

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> patient]'s condition during the observation period, and to act upon the situation after the 24-hour period when his abdominal pain persisted and his condition worsened.
>
> Again, acute appendicitis was the working diagnosis, and with the emergence of graver symptoms after the 24-hour observation, [the doctor] ruled out surgery for no apparent reason. We, likewise, note that the records are devoid of showing of any reasonable cause which would lead [the doctor] to overrule appendectomy despite the initial diagnosis of appendicitis. Neither was there any showing that he was entertaining another diagnosis nor [that] he took appropriate steps towards another diagnosis.[157]

In these cases, the physicians failed to take timely action on the observed deterioration or worsening of the patients' conditions. While in *Jarcia, Jr.*, the Court found that evidence was insufficient to establish guilt beyond reasonable doubt; nevertheless, the physicians were found liable for damages.[158] The negligence in these cases was established by making an inquiry into the management of the patient, taking into account the available facts at the time the physician makes a diagnosis or decides on an intervention.[159] The Court was careful to clarify that it was not deciding on the correctness of the diagnosis, but considered whether the failure to timely diagnose or intervene was the result of actions or omissions that failed to meet the standard of care expected of reasonably prudent physicians under the circumstances.[160]

D. Doctrine of Informed Consent

The failure to obtain informed consent from patients has long been recognized as a violation of a physician's duty.[161] The basis of the "doctrine of informed consent" is the patient's right to self-determination — "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation

157. *Cabugao*, 731 SCRA at 233-34.

158. *Jarcia, Jr.*, 666 SCRA at 358.

159. *Id.*

160. *Id.* at 344.

161. *See generally* Christopher White, et al., *Informed Consent to Medical and Surgical Treatment*, *in* LEGAL MEDICINE 337-43 (Shafeek Sandy Sanbar ed., 2007).

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without his patient's consent commits an assault, for which he is liable in damages."[162]

In 2011, the Supreme Court in *Li v. Soliman*[163] discussed the doctrine of informed consent in relation to medical liability, identifying its elements as:[164]

> (1) the physician had a duty to disclose material risks;
>
> (2) he [or she] failed to disclose or inadequately disclosed those risks;
>
> (3) as a direct and proximate result of the failure to disclose, the patient consented to treatment she [or he] otherwise would not have consented to; and
>
> (4) plaintiff was injured by the proposed treatment.
>
> The gravamen in an informed consent case requires the plaintiff to 'point to significant undisclosed information relating to the treatment which would have altered her [or his] decision to undergo it.'[165]

The case involved an 11-year-old patient diagnosed with osteosarcoma, a type of cancer that affected the patient's right leg, leading to its amputation.[166] The patient was referred to an oncologist for chemotherapy after the operation, but the patient died during the treatment process.[167] The parents claimed that the doctor assured them that the child would recover with a 95% chance of healing with chemotherapy, and that they were not informed of all the side effects.[168] The doctor denied negligence and asserted that the patient's parents were informed of the material risks in the administration of the chemotherapy drugs.[169] The Court said that

> by the nature of the disease itself, each patient's reaction to the chemical agents[,] even with pre-treatment laboratory tests[,] cannot be precisely

162. Mohammad Yousuf Rathor, et al., *Informed Consent: A Socio-Legal Study*, 55 MED. J. MALAY. 423, 423 (2011) (citing Schloendorff v. New York Hospital, 211 N.Y. 125, 129 (1914) (U.S.)).

163. Li v. Soliman, 651 SCRA 32 (2011).

164. *Id.* at 59.

165. *Id.* (citing Davis v. Kraff, 405 Ill. App.3d 20, 28-29 (2010) (U.S.)).

166. *Li*, 651 SCRA at 41.

167. *Id.*

168. *Id.* at 42.

169. *Id.*

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> determined by the physician. That death *can* possibly result from complications of the treatment or the underlying cancer itself, immediately or sometime after the administration of chemotherapy drugs, is a risk that cannot be ruled out, as with most other major medical procedures, *but* such conclusion can be reasonably drawn from the general side effects of chemotherapy already disclosed.
>
> As a physician, petitioner can reasonably expect the respondents to have considered the variables in the recommended treatment for their daughter afflicted with a life-threatening illness. [I]t is difficult to give credence to respondents claim that petitioner told them of [a] 95% chance of recovery for their daughter, as it was unlikely for doctors like petitioner who were dealing with grave conditions such as cancer to have falsely assured patients of chemotherapy's success rate. Besides, informed consent laws in other countries generally require only a reasonable explanation of potential harms, so specific disclosures such as statistical data, may not be legally necessary.[170]

In this case, the Court evaluated possible liability in relation to the elements of informed consent, which contains in essence the elements of duty, breach of duty, injury, and proximate causation of medical negligence.[171] The element that requires further consideration is material risk.[172] The trend has been to shift from considering material risk from the point of view of the physician to one that is centered on the patient. In the 1992 case of *Rogers v. Whitaker*,[173] decided by the High Court of Australia, a risk was defined as material if "in the circumstances of a particular case, a reasonable person in the patient's position, if warned of the risk, would likely attach significance to it."[174]

The concept of material risk has been evolving. For instance, in 1985, in the United Kingdom, not informing the patient of the risk of paraplegia from cervical cord decompression — which occurs in less than 1% of cases — was not considered negligence.[175] In contrast, the High Court of Australia ruled in *Rogers* that the physician should have disclosed the

170. *Id.* at 60 (citing Arato v. Avedon, 5 Cal.4th 1172, 1188 (1993) (U.S.)). *See also Li*, 651 SCRA at 73 (J. Brion, concurring opinion).

171. *Li*, 651 SCRA at 59.

172. *Id.* at 58.

173. Rogers v. Whitaker, 175 CLR 479 (1992) (Austl.).

174. *Id.* at 490.

175. Sidaway v. Board of Governors of the Bethlem Royal Hospital, A.C. 871, 902-05 (1985) (U.K.).

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possibility of developing a rare post-operative complication (1:14000) resulting to blindness (sympathetic ophthalmia in the opposite eye), considering it a material risk which would have been significant to the patient.[176]

In Philippine jurisdiction, the Supreme Court has said —

> The element of ethical duty to disclose material risks in the proposed medical treatment cannot thus be reduced to one simplistic formula applicable in all instances. Further, in a medical malpractice action based on lack of informed consent, 'the plaintiff must prove both the duty and the breach of that duty through expert testimony.' Such expert testimony must show the customary standard of care of physicians in the same practice as that of the defendant doctor. [177]

Thus, the Court provided guidance when it ruled that the duty to disclose material risks cannot be reduced to one simplistic formula applicable in all instances, and that specific disclosures of statistical data may not be necessary.[178]

Physicians often need to balance what information to provide the patient. For instance, while the risk of death for any surgical operation exists, in proposing a possible life-saving surgical treatment, some physicians weigh whether it would do more harm to a patient to be informed that he or she could die during surgery, even if the risks are minimal. There are studies that report that the risk of death from administration of anesthesia is one in 100,000.[179] Given the risks, following a simplistic formula may mean that everyone about to undergo any surgery that requires administration of anesthesia should be informed that they could die.

In *Rosit v. Davao Doctors Hospital*,[180] a recently decided case involving a patient in Davao who had fractured his jaw after a motorcycle accident, Supreme Court also discussed the doctrine of informed consent.[181] The

176. *Rogers*, 175 CLR at 489-90.

177. *Li*, 651 SCRA at 60-61 (citing Mason v. Walsh, 26 Conn. App. 225, 229 (1991) (U.S.)).

178. *Id.*

179. Guohua Li, et al., *Epidemiology of Anesthesia-related Mortality in the United States, 1999–2005*, 110 ANESTHESIOLOGY 759, 764 (2009).

180. Rosit v. Davao Doctors Hospital, 776 SCRA 303 (2015).The case is also discussed under the Section of doctrine of *res ipsa loquitur*.

181. *Id.* at 308.

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patient was operated on by a physician.[182] To immobilize the mandible, the physician needed to fasten a metal plate to the jaw using metal screws.[183] The operation required the smallest screws obtainable but the available screws on hand were bigger.[184] The physician knew that there were smaller screws available in Manila but he did not inform the patient of such fact, believing that the patient will not be able to afford it.[185] Instead, he cut the available screws to make them smaller.[186] In this case, the Supreme Court considered the information withheld from the patient as a material risk —

> [The physician] had the duty to fully explain to [the patient] the risks of using large screws for the operation. More importantly, he concealed the correct medical procedure of using the smaller titanium screws mainly because of his erroneous belief that [the patient] cannot afford to buy the expensive titanium screws.[187]

After the operation, the patient was in pain and could not open his mouth.[188] The X-ray showed that the screw used on him touched his molar.[189] He had to be operated on again in another institution, where the plate and screws were replaced with a smaller titanium plate and screws.[190] After the second operation, the patient was able to eat and speak well and could open and close his mouth normally.[191]

While the Court based its decision on the application of the doctrine of *res ipsa loquitur*, it also found the physician in bad faith for withholding material information which would have been vital in the decision of the patient in going through with the operation with the materials at hand, in violation of the doctrine of informed consent.[192]

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182. *Id.*

183. *Id.*

184. *Id.*

185. *Id.*

186. *Rosit*, 776 SCRA at 308.

187. *Id.* at 321-22.

188. *Id.* at 308.

189. *Id.*

190. *Id.*

191. *Id.* at 309.

192. *Rosit*, 776 SCRA at 321-22.

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E. Captain of the Ship Doctrine

The "Captain of the Ship doctrine" is usually applied to hold the lead surgeon of an operation accountable for practically everything that happens in the operating room.[193] The basis of the doctrine was the assumption that the surgeon controlled or had the power to control the activities of the hospital healthcare professionals involved in a patient's operation.[194] This was explained in *Ramos*, where the Supreme Court ruled that the head of the surgical team is liable under the Captain of the Ship doctrine, "because it is the surgeon's responsibility to see to it that those under him [or her] perform their task in the proper manner."[195]

The doctrine has even been used to hold the surgeon accountable for injuries sustained by a patient while in the recovery room after the operation.[196] The patient received injuries, either due to the droplight or blood pressure, but the surgeon was found liable because both instruments were deemed within his exclusive control as the physician in charge or as "captain of the ship."[197]

Even in the operating room, if the assumption that the surgeon was in control was ever true, it became less and less true because of the increasing complexity of operating rooms, the trend towards specialization, and the emergence of skilled nurses.[198] In one case decided in the United States

193. *Cantre*, 522 SCRA at 556 (citing BLACK'S LAW DICTIONARY 192 (5th ed. 1979)).

194. *Id.*

195. *Ramos*, 321 SCRA at 619.

196. *Cantre*, 522 SCRA at 550-52.

197. *Id.* at 556-57.

198. SOLIS, *supra* note 1, at 238. The decreasing popularity of the Captain of Ship doctrine was attributed to the following reasons:

> (1) Increasing complexity and sophistication of the operating room facilities requiring technical knowledge beyond the scope of knowledge of the surgeon thereby making supervision impossible[;]
>
> (2) Importance of encouraging the surgeon to concentrate on his [or her] own job[; and]
>
> (3) Liability for [a] damage suit has shifted from surgeon to hospital.

Id.

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(U.S.), it was held that the Captain of the Ship doctrine should not be applied where the nurse performs routine tasks[,] even though done pursuant to a doctor's orders.[199] In foreign jurisdiction, the trend has been to limit the application of the Captain of the Ship doctrine.[200] This argument was not accepted by the Supreme Court in the motion for reconsideration of *Ramos v. Court of Appeals*.[201] On the issue of whether the surgeon should be made liable for acts of the anesthesiologists, the Court rejected the argument to limit the application of the Captain of the Ship doctrine —

> That there is a trend in American jurisprudence to do away with the [Captain of the Ship] doctrine does not mean that this Court will *ipso facto* follow said trend. Due regard for the peculiar factual circumstances obtaining in this case justify the application of the [Captain of the Ship] doctrine.[202]

The Supreme Court has recently decided on two cases significant to the development of the Captain of the Ship doctrine. In *Bontilao v. Gerona*,[203] while discussing the doctrine of *res ipsa loquitur*, the Court said that the anesthesiologist, in performing his or her duties, was not under control of the surgeon —

> [T]he instrument which caused the damage or injury was not even within respondent's exclusive management and control as Dr. Jabagat was exclusively in control and management of the anesthesia and endotracheal tube. Requirements before the doctrine of *res ipsa loquitur* can allow the mere existence of an injury to justify a presumption of negligence on the part of the person who controls the instrument causing the injury[.][204]

While the discussion was on the application of the doctrine of *res ipsa loquitur*, *Bontilao* remains to be an indication that the Court may be willing to

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199. Patdu, *supra* note 5, at 73 (citing Nelson v. Trinity Medical Center, 419 N.W.2d 886 (N.D. 1988) (U.S.)). In *Nelson v. Trinity Medical Center*, the court cited the earlier case of *Elizondo v. Tavarez* where it was held that a doctor who ordered the insertion of a tube down a patient's throat was not liable when a nurse negligently inserted that tube. *Nelson*, 419 N.W.2d at 892 (citing Elizondo v. Tavarez, 596 S.W.2d 667 (Tex. Civ. App. 1980) (U.S.)).

200. *Id.*

201. Ramos v. Court of Appeals, 380 SCRA 467 (2002).

202. *Id.* at 490.

203. Bontilao v. Gerona, 630 SCRA 561 (2010).

204. *Id.* at 571.

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depart from the ruling in *Ramos* particularly on the relationship between surgeons and anesthesiologists.

In the case of *Mendoza v. Casumpang*,[205] the Supreme Court reiterated that a surgical operation is the responsibility of the surgeon performing it.[206] In this case, the patient underwent an operation involving the removal of her uterus.[207] Three months after the operation, while taking a bath, she noticed something protruding from her genital.[208] Because the doctor was unavailable, the patient went to see another physician who extracted a foul smelling, partially expelled rolled gauze from her cervix.[209] This prompted the filing of a damage suit against the doctor who operated on her.[210] Here, the doctor claims that no gauze or surgical material was left in patient's body after her surgery, relying on the surgical sponge count in the hospital record.[211]

The Court, however, was not persuaded —

> [The patient] did not undergo any other surgical operation. And it would be much unlikely for her or for any woman to inject a roll of gauze into her cervix.
>
> ...
>
> A surgical operation is the responsibility of the surgeon performing it. He [or she] must personally ascertain that the counts of instruments and materials used before the surgery and prior to sewing the patient up have been correctly done. To provide an example to the medical profession and to stress the need for constant vigilance in attending to a patient's health, the award of exemplary damages in this case is in order.[212]

These cases decided by the Supreme Court should prompt a review of the responsibility of the surgeon in the operating room, whether they should remain to be considered responsible even for routine tasks performed by nurses, and with due consideration of how the practice of medicine has

205. Mendoza v. Casumpang, 668 SCRA 436 (2012).

206. *Id.* at 439.

207. *Id.* at 437.

208. *Id.* at 437-38.

209. *Id.*

210. *Id.* at 438.

211. *Mendoza*, 668 SCRA at 438.

212. *Id.* at 439.

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moved towards greater specialization. In applying the Captain of the Ship doctrine, or in determining vicarious liability of a physician, each case should be evaluated based on attendant factual circumstances. Physicians, when being made liable for acts of another, should be shown to actually have moral culpability. This requires a demonstration that the person who committed the acts or omissions constituting negligence is actually under the control of the physician, and that the physician is in a position to prevent the harm. This is more consistent with vicarious liability and principles of negligence under the Civil Code.

IV. MEDICAL LIABILITY SYSTEM AND PATIENT SAFETY

Evident from the Code of Hammurabi (2200 B.C.) — described as the "first formal code of medical law, setting for the organization, control, duties, and liabilities of the medical profession,"[213] — is that those providing treatment have always been held accountable for acts that cause injury to patients. Under this Code, for example, "[i]f a physician operate[s] on a man for a severe wound with a bronze lancet and cause[s] the man's death; or open an abcess (in the eye) of a man with a bronze lancet and destroy[s] the man's eye, they shall cut off his fingers."[214] The Code imposes harsh penalties for what would be perceived as professional malpractice today.

Globally, the medical liability system is generally based on a "finding of fault," often integrated in administrative, civil, or criminal law.[215] In the previous Sections, recent cases decided by the Court provide examples of how cases are decided under the medical liability system in the country.

From a legal perspective, approaching a case of apparent medical negligence involves an examination of the elements of duty, breach of duty, injury, and proximate causation.[216] In practice, this often means finding a physician willing to testify about a colleague's negligence. A fault-based system is viewed as creating a mindset that whenever a patient does not get

213. Cyril H. Wecht, *Utilization of Forensic Science in the Civil and Criminal Justice Systems: Forensic Use of Medical Information*, *in* LEGAL MEDICINE 661 (Shafeek Sandy Sanbar ed., 2007) (citing THE CODE OF HAMMURABI, KING OF BABYLON: ABOUT 2250 B.C. 71-77 (Robert Francis Harper trans., 1904)).

214. THE CODE OF HAMMURABI, *supra* note 213, ¶ 218.

215. *See, e.g.*, SIMON TAYLOR, MEDICAL ACCIDENT LIABILITY AND REDRESS IN ENGLISH AND FRENCH LAW 145 (2015).

216. *See Borromeo*, 781 SCRA at 539 (citing *Garcia-Rueda*, 278 SCRA at 778; *Flores*, 571 SCRA at 91; & *Reyes*, 341 SCRA at 769).

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better, or dies in the course of treatment, a healthcare provider has been remiss in his or her duties. To those practicing medicine, however, medical negligence is never a straightforward case. The standards are constantly evolving to accommodate advances, experimental treatments, and new technology. In addition, patients with the same condition do not always present the same symptoms, and the disease does not progress at the same rate. Indeed, physicians have been given a sacred duty — "[a] mistake, through gross negligence or incompetence or plain human error, may spell the difference between life and death. In this sense, the doctor plays God on his [or her] patient's fate."[217]

Unfortunately, a patient who enters a hospital expecting cure may, in some cases, deteriorate or even die. Physicians are not gods, and they do not warrant cure, because even if they have done their duties to the best of their abilities, their best may not always be enough.

In the 1999 landmark study *To Err is Human*,[218] published by the Institute of Medicine, it was estimated that 98,000 patients die in the U.S. every year due to medical errors.[219] A more recent study puts the number at 440,000.[220] The staggering numbers were recognized as being indicative of a serious problem.[221] In the first place, patients expect to get better when seeking medical attention in healthcare facilities.[222] That many patients died due to preventable medical errors was unacceptable.[223] The study marked the vigorous efforts that would characterize the global initiatives in the last decade directed to making patient safety a top priority.[224] There are views

217. *Ramos*, 321 SCRA at 588-89.

218. INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn, et al. eds., 2000).

219. *Id.*

220. John T. James, *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAF. 122, 127 (2013).

221. *Id.*

222. *Id.*

223. *Id.*

224. Joan M. Gilmour, Patient Safety, Medical Error and Tort Law: An International Comparison: Final Report, at v-vi, *available at* https://apps.osgoode.yorku.ca/osgmedia.nsf/0/094676DE3FAD06A5852572330059253C/$FILE/FinalReport_Full.pdf (last accessed May 12, 2017).

Pennsylvania became the first state to require hospitals to provide written notice to patients about a serious event within seven days of its occurrence. Several

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that the current medical liability system adopted in most jurisdictions, based on a finding of fault, is an impediment to achieving a culture of patient safety.[225]

It bears emphasis that not every adverse event that occurs in the course of medical treatment results from medical error, and that a medical error does not automatically mean that there is negligence or professional malpractice. A litigious society does not view adverse events in the same way. There are studies showing that majority of cases being filed on medical malpractice do not actually involve negligence —

> Negligence is actually rarely present in most alleged cases of medical malpractice. In one study in New York, adverse events were reported in 3.7% of all hospitalizations. In over 70% of these cases, however, no negligence was present. In another closed claim study performed at Harvard, only 15% of medical malpractice cases actually contained negligence. And in a 2005 Congressional Report, over 80% of malpractice cases reviewed actually contained no negligence. One explanation for this is that healthcare providers, from medical assistants to nurses to physicians, tend to be highly motivated individuals. Rather than being motivated by money, most healthcare practitioners tend to be motivated by professional or moral ideals to deliver high quality care and to 'do no harm.' As such, negligence is not usually at the heart of most medical errors.[226]

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states are considering "apology laws," which would prohibit a physician's apology from being used in litigation. Patrice M. Weiss & Francine Miranda, *Transparency, Apology and Disclosure of Adverse Outcomes*, 35 OBSTET. GYNECOL. CLIN. N. AM. 53, 56-59 (2002) (citing Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model To Manage Disclosure Of Errors And Adverse Events To Patients*, 23 HEALTH AFF. 22, 22 (2004)).

In 2008, the Philippines, through the DOH, issued the National Policy for Patient Safety signifying the country's commitment towards promoting patient safety. Department of Health, Administrative Order No. 2008-0023, Series of 2008 [A.O. No. 2008-0023, s. 2008] (July 30, 2008).

225. Gilmour, *supra* note 224, at 12-13.

226. David H. Sohn, *Negligence, genuine error, and litigation*, 6 INT. J. GEN. MED. 49, 50 (2013) (citing Troyen A. Brennan, et al., *Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I*, 13 QUAL SAF HEALTH CARE 145, 145-52 (2004); INSTITUTE OF MEDICINE, *supra* note 219; PAUL C. WEILER, ET AL., A MEASURE OF MALPRACTICE MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (2003); & United States Congress Joint Economic Committee, The Perverse Nature of the Medical Liability System, *available at* https://www.jec.senate.gov/public/

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Laws, through its corrective, compensatory, and regulatory function, aim to provide a means for victims of medical negligence to obtain redress for their grievances. A framework based on a finding of fault has, however, been criticized as being both ineffective in compensating victims of medical negligence[227] and counterproductive to achieving a culture of patient safety.[228] One problem that has been observed in fault-based systems is how the threat of litigation has led to increasing insurance premiums and the practice of defensive medicine, which increases healthcare expenditure and compromises quality of care. This fear of litigation also tends to be a limiting factor in research initiatives intended to generate more information on patient safety.

It has been suggested that "the name and shame aspect of liability encourages secrecy rather than the candor essential for patient safety."[229] In a local study evaluating perceived safety culture in hospitals, it was recommended that

> [r]ecording and evaluating incidents and communication must be given greater emphasis in creating a positive safety culture.
>
> ...
>
> The hospital administration must reduce the fear of blame culture and create a climate of open communication and continuous learning. Error-reporting should not be viewed as an end in itself, but rather as a means of

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_cache/files/1d42a169-05de-444f-954d-e0497581fcd4/the-perverse-nature-of-the-medical-liability-system-03-21-05.pdf (last accessed May 12, 2017)).

227. *See generally* American Association for Justice, Medical Negligence: A Primer for the Nation's Health Care Debate, *available at* www.pleasantlaw.com/library/Medical_Negligence_Primer_AAJ.pdf (last accessed May 12, 2017).

228. *See generally* Oliver L. Quick, *Patient safety and the problem and potential of law*, 28 J. PROF. NEGL. 78, 78 (2012) (citing Ian Kennedy, The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol, at 441, *available at* webarchive.nationalarchives.gov.uk/20090811143745/http:/www.bristol-inquiry.org.uk/final_report/the_report.pdf (last accessed May 12, 2017)) & Gilmour, *supra* note 224.

229. Quick, *supra* note 228, at 78 (citing Kennedy, *supra* note 228).

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learning from mistakes and the first step towards elimination of harm and improvement of patient safety.[230]

At present, despite global attention to promotion of patient safety, lawsuits involving alleged medical negligence continue to be filed in courts or other quasi-judicial bodies. The trend, in fact, has been increasing.[231]

The landmark paper *To Err is Human*, suggests that most medical errors are the result of unavoidable human error, which can only be reduced through system changes.[232] It emphasizes that building safety into processes of care is a more effective way to reduce errors than blaming individuals.[233] While some countries have adopted "no fault schemes," a majority continue to adhere to the "finding of fault" as a central principle in medical liability systems.[234] Future studies should consider possible reforms in the medical

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230. Fritz Gerald V. Jabonete & Leonora R. Concepcion, *Perceived Safety Culture of Healthcare Providers in Hospitals in the Philippines*, 2 J. SCI., TECH. & ARTS RES. 1, 10 (2016).

231. According to Rico Buraga,

> [d]ata from the Professional Regulatory Commission (PRC) indicates (per PRC Board of Medicine August 2002 data, there are 585 docketed cases with 176 malpractice or gross negligence cases) that over a hundred have been reported to them as early as 1993. The Center for People's Health Watch, a Cebu-based non-governmental organization has documented 53 cases of medical malpractice from 1992 to 1996 in Visayas alone.

Rico Buraga, Blog Post, *Medical Malpractice in the Philippines: A Policy Issue*, Dec. 2012: 9:46 p.m., BLOGSPOT, *available at* ricoburaga.blogspot.com/2012/12/medical-malpractice-in-philippines.html (last accessed May 12, 2017).

A blog site entitled "Victims of Medical Malpractice (Philippines)" features real stories of people who claim to be victims of medical malpractice. *See generally Victims of Medical Malpractice (Philippines)*, BLOGSPOT, *available at* victimsmedmalpractice.blogspot.com (last accessed May 12, 2017).

232. Sohn, *supra* note 226, at 50. (citing TO ERR IS HUMAN, *supra* note 219).

233. INSTITUTE OF MEDICINE, *supra* note 219, at 4-5.

234. A book edited by Ken Oliphant and Richard W. Wright discusses "no fault schemes" adopted in Nordic countries (1970) (Sweden (1975), Finland (1984), Norway (1988), Denmark (1992)), Austria (2001), France (2002), Belgium (2007), Japan (2009), and Poland (2011). In the Philippines, United States, United Kingdom, most European Countries, and most Asian Countries, the Medical Liability System is based on a finding of fault. *See generally* MEDICAL

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liability system geared towards allowing law to fulfill its corrective, compensatory, and regulatory functions while promoting a culture of patient safety.

MALPRACTICE AND COMPENSATION IN GLOBAL PERSPECTIVE (Ken Oliphant & Richard W. Wright eds., 2013).

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