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MEDICAL MALPRACTICE LAW IN THE PHILIPPINES: PRESENT STATE AND FUTURE DIRECTIONS

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"The regimen I will adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion. Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction, of male or female, slave or free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets."

- Oath of Hippocrates

I. INTRODUCTION

There is a growing concern about the prevalence of medical malpractice, and the seeming helplessness of its victims.[1] People are concerned that countless persons are victimized by medical negligence, and that these victims are left without a remedy, their injuries not redressed. The prevalence of medical negligence is indeed alarming: in the United States for example, a country with a more advanced health care system than that of the Philippines, the incidence of medical malpractice is disturbing. According to one report,[2] "depending on which statistics you believe,

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[1] *See* Dulce M. Arguelles and Darwin G. Amojelar, *Medical Malpractice: Is There Such a Thing in the Philippines.* Manila Times (Sunday Times Magazine), September 1, 2002, *available at* <http://www.manilatimes.net/ national/2002/sept/01/ weekend/20020901wek1.html>. The rising incidence of medical malpractice is attributed to the commercialization of healthcare and medical education, limited national budget for health, and doctors in public hospitals who are "overworked, overburdened and underpaid."

[2] Michael D. Lemonick, *Doctors' Deadly Mistakes*, TIME, December 13, 1999, *cited in* Ramos v. Court of Appeals, G.R. No. 124354, December 29, 1999, 321 SCRA 584, 589 n.1.

the number of Americans killed by medical screw-ups is somewhere between 44,000 and 98,000 every year – the eighth leading cause of death even by the more conservative figure, ahead of car crashes, breast cancer and AIDS."

Also, in the United States, a supposedly litigious society where doctors complain of too many malpractice suits,[3] there is still evidence indicating that a majority of medical malpractice cases do not reach the courts for appropriate remedy. According to a landmark study by the Harvard Medical and Law Schools, based on a sample of New York hospitals, only about 12.5 % of malpractice victims filed claims for damages,[4] leading the Harvard team to conclude that "the incidence of litigation remains far below the incidence of injuries caused by medical negligence."[5] There is no similar study in the Philippines, but the number of medical malpractice suits is probably lower.[6]

In response to this prevalence of medical malpractice and the infrequency of malpractice suits, our lawmakers came up with various legislative bills intended to address the problem. There is no dispute about the desirability of a more effective medical care system and more competent and responsible doctors. But are the legislative proposals intended to achieve these goals adequate and appropriate to attain them? Will they solve the problem? What are the possible repercussions? If the current legislative proposals are inadequate, what would be a better alternative approach? These are the main issues we shall address in this paper.

We shall first discuss the present state of medical malpractice law in the Philippines to lay the background of our study. Then we shall present the proposals suggested by our lawmakers in dealing with malpractice, as well as our criticism of such proposals. Finally, we will present our own modest proposal.

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[3] *See* W. John Thomas, *The Medical Malpractice "Crisis": A Critical Examination of a Public Debate*, 65 Temp. L. Rev. 459, 460-464 (1992).

[4] *Id*, at 485.

[5] *Id.*, at 485, n.175.

[6] "Anecdotal speculative data reports 'thousands' of malpractice cases. However, per PRC Board of Medicine August 2002 data, there are 585 docketed cases with 176 malpractice or gross negligence cases (30%). There are 27,000 PMA practicing doctor members. Assuming each physician sees 10 cases per day, in a year (5 clinic days a week) about 648 million patients would have been attended. About 1 in 3.68 million attended patients appear to be the presumed malpractice incidence, a mere 0.00002716%." Ramon F. Abarquez, Jr., *Re: House Bill No. 4955 An Act Punishing the Malpractice Of Any Medical Practitioner in the Philippines and for Other Purposes or "Medical Malpractice Act of 2002," at* <http://www.pcp.org.ph/main.php?fid=4955_2>.

II. PRESENT STATE OF MEDICAL MALPRACTICE LAW IN THE PHILIPPINES

A. MEDICAL MALPRACTICE, IN GENERAL

Malpractice is defined as the bad or unskillful practice on the part of a physician or surgeon resulting in injury to the patient,[7] or, more broadly, a physician's breach of a duty imposed on him by law.[8] As defined by our Supreme Court, medical malpractice is 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"[9] (although actually, the injury need not only be "bodily").

Medical malpractice covers not only the conduct of physicians and surgeons but also other persons engaged in health-care functions,[10] like dentists, nurses, physical therapists, psychotherapists, medical technologists, and even juridical persons like hospitals and health maintenance organizations (HMO's). This paper would, however, focus on the liability of physicians for simplicity and brevity.

In its scope, medical malpractice "comprises all acts or omissions of a physician or surgeon as such to a patient as such which may make the physician or surgeon either criminally or civilly or administratively liable."[11]

In a typical medical malpractice case, the physician, because of negligence, causes injury to the patient. A common example is when the surgeon negligently leaves a foreign object (sponge, gauze pad, drainage tube, hypodermic needle, etc.) inside the body of the patient.[12] Failure to diagnose correctly the nature of an ailment due to lack of skill or care is also an example of medical negligence.[13] Another example is failure of the physician to consult a specialist, if necessary, or failure to refer the patient to a specialist.[14] A physician may also be negligent in

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[7] *See* Malone v. Univ. of Kansas Medical Center, 552 P.2d 885 (Kan.1976).

[8] *See* Snead v. U.S., D.C., 595 F.Supp. 658 (D.C.,D.C.,1984).

[9] Cruz v. Court of Appeals, G.R. No. 122445, Nov. 18, 1997.

[10] *See* Watts v. Cumberland County Hospital. System, Inc., 330 S.E.2d 242 (N.C.App.,1985).

[11] Physicians' and Dentists' Bureau v. Dray, 111 P.2d 568, 569 (Wash.1941).

[12] *See* Batiquin v. Court of Appeals, G.R. No. 118231, July 5, 1996, 258 SCRA 334, 344-346 (1996) (where a piece of the doctor's rubber gloves was left inside the uterus of the patient).

[13] *See* Jackson v. U.S., 577 F.Supp. 1377 (D.C.Mo.,1983); Reynolds v. Struble, 18 P.2d 690 (Cal.App. 1 Dist. 1933); Levenson v. Ruble, 30 N.E.2d 840 (Mass. 1941).

[14] *See* Burks v. Meredith, 546 S.W.2d 366 (Tex.Civ.App.,1977); Buck v. U.S., 433 F.Supp. 896 (D.C.Fla. 1977); Robertson v. Counselman, 686 P.2d 149 (Kan.,1984); Rise v. U.S., 630 F.2d 1068 (C.A.Ga., 1980).

improperly prescribing drugs to his patients which may injuriously result in overdose, conflict with other drugs taken, or drug dependence.[15]

It should be made clear, however, that a physician is not liable as negligent merely because the treatment is unsuccessful or has a poor result, as long as he exercised the required degree of skill and care.[16] It is often said that doctors "are not guarantors of care. They do not even warrant a good result. They are not insurers against mishaps or unusual consequences. Furthermore they are not liable for honest mistakes of judgment."[17] Negligence is not presumed; it must be affirmatively proved.[18]

Medical malpractice is a "particular form of negligence, which consists in the failure of a physician or surgeon to apply to his practice of medicine that degree of care and skill which is ordinarily employed by the profession generally, under similar conditions, and in like surrounding circumstances."[19] However, it is a misconception that medical malpractice is limited to cases of **negligence** (under article 2176 of the Civil Code). Liability for medical malpractice may also come from other sources,[20] such as (a) **intentional torts**, under the Human Relations provisions of the Civil Code, articles 19-36; (b) **contracts**; (c) **crimes**; and (d) **other laws**, such as the Medical Act (R.A. No. 2382) and P.D. No. 223 (creating the Professional Regulatory Commission). These sources of malpractice liability will be further discussed below in terms of the remedies available to malpractice cases.

B. AVAILABLE REMEDIES

The present state of Philippine law on medical malpractice may be analyzed best in terms of the legal remedies available to a victim of medical malpractice. Three main legal remedies (substantive and procedural) are currently available for malpractice cases – civil, criminal, and administrative remedies.

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[15] Jones v. Irvin, 602 F.Supp. 399 (D.C.Ill.,1985).

[16] *See* Shevak v. U.S., 528 F.Supp. 427 (D.C.Tex., 1981); Tannenbaum v. Klein, 299 N.Y.S. 119 (N.Y.A.D. 2 Dept. 1937); DeWitt v. U.S., 593 F.2d 276 (C.A.Ind., 1979); Larkin v. State, 446 N.Y.S.2d 818 (N.Y.A.D., 1982).

[17] Cruz v. C.A., G.R. No. 122445, Nov. 18, 1997, n.1.

[18] TOLENTINO, 5 COMMENTARIES ON THE CIVIL CODE 601 (1992), citing Barcelo v. Manila Electric, 29 Phil. 351; Cea v. Villanueva, 18 Phil. 538; Molina v. De la Riva, 32 Phil. 277; etc.

[19] Reyes v. Sisters of Mercy Hospital, G.R. No. 130547, October 3, 2000, 341 SCRA 760, 769 (2000).

[20] CIVIL CODE, Art. 1157. "Obligations arise from: (1) Law; (2) Contracts; (3) Quasi-contracts; (4) Acts or omissions punished by law; and (5) Quasi-delicts."

1. Civil Remedies

a. Civil Action Based on Quasi-Delicts

A victim of medical malpractice can file a civil action to recover damages for the injury he has suffered. Usually, such civil action is based on quasi-delict if the injury is due to negligence of the physician. The legal basis is article 2176 of the Civil Code, which provides:

> *Article 2176.* Whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done. Such fault or negligence, if there is no pre-existing contractual relation between the parties, is called quasi-delict.

Liability for quasi-delict requires the following elements: (1) there must be an unlawful act or omission amounting to fault or negligence, imputable to the defendant; (2) damage or injury to the plaintiff; (3) such damage or injury to the plaintiff was the natural and probable, or direct and immediate consequence of defendant's wrongful act or omission; and (4) there is no pre-existing contractual relations between the plaintiff and the defendant.[21]

The patient-physician relationship is typically contractual, express or implied.[22] However, even if a quasi-delict requires that there be "*no pre-existing contractual relation* between the parties,"[23] quasi-delict is nevertheless used as legal basis for medical negligence actions. Thus, in the case of *Cruz v. Court of Appeals*,[24] the Supreme Court expressly said that "in this jurisdiction, however, such [malpractice] claims are most often brought as a civil action for damages under Article 2176 of the Civil Code. . . ." Moreover, it is already well established that "the act that breaks the contract may also be a tort."[25]

The central element that must be proved in an action for quasi-delict is the existence of *fault or negligence*. Article 1173 of the Civil Code defines it as "the omission of that diligence which is required by the nature of the obligation and corresponds with the circumstances of the persons, of the time and of the place." Negligence presupposes that there exists a standard of behavior. Generally, this

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[21] CEZAR SANGCO, 1 TORTS AND DAMAGES 414 (1993).

[22] *See* Spencer v. West, 97 ALR 2d 1224 (La.App. 1961).

[23] CIVIL CODE, Art. 2176.

[24] G.R. No. 122445, Nov. 18, 1997.

[25] Carrascoso vs. Air France, G.R. No. 21438, September 28, 1966, 18 SCRA 155 (1966). *See also*, Singson v. Bank of Philippine Islands, 23 SCRA 1119 (1968), and Tayag v. Alcantara, 98 SCRA 723 (1980).

standard is that of a "good father of a family." For doctors, the degree of care and diligence required is higher because they are dealing with human lives.[26] The Supreme Court, in the cases of *Garcia-Rueda v. Pascasio*[27] and *Cruz v. Court of Appeals*,[28] citing American cases,[29] established the following standard of care for physicians and surgeons:

> [Doctors] have a duty to use at least the same level of care that any other reasonably competent doctor would use to treat a condition under the same circumstances. 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. Consequently, in the event that any injury results to the patient from want of due care or skill during the operation, the surgeons may be held answerable in damages for negligence.

For medical malpractice, negligence is any act or omission falling short of the required *standard of care*, which ordinarily must be proven by a medical expert.

b. Civil Action Based on Intentional Torts

As originally conceived by the Code Commission, a *quasi-delict*, strictly speaking, includes only negligent and not intentional acts,[30] unlike the broader Anglo-American concept of *tort*. However, medical malpractice is not necessarily limited to cases of negligence. It may also be *intentional*. It will be remembered that quasi-delicts or negligent torts are just one class of torts, the others being *intentional* torts and *strict liability* torts.[31] However, quasi-delicts almost always overshadow the other kinds of tort. "At present, almost every tort case is treated as a quasi-delict, with the result that quasi-delicts have pre-empted the area of tort law reserved for intentional torts. The differences which distinguish a quasi-delict from an intentional tort are beginning to be eroded."[32]

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[26] Reyes v. Sisters of Mercy Hospital, 341 SCRA 760, 780 (2000). *See also* U.S. v. Pineda, 37 Phil. 456 (on pharmacists).

[27] G.R. No. 118141, September 5, 1997, 278 SCRA 769 (1997).

[28] G.R. No. 122445 (1997).

[29] Hoover vs. Williamson, 203 A.2d 861 (MD. 1964); Gore vs. Board of Medical Quality, 110 Cal App 3d 184 (Cal.App.2.Dist., 1980).

[30] REPORT OF THE CODE COMMISSION, at 161-162.

[31] *But see* Finn v. G.D. Searle & Co., 200 Cal. Rptr. 870 (Cal., 1984) (Strict liability may not be imposed on physician for failure properly to diagnose patient's condition).

[32] ANTONIO T. CARPIO, *Intentional Torts in Philippine Law*, 47 PHIL. L. J. 649, 649-50 (1972).

Intentional torts in medical malpractice may come in various forms:[33] (1) *physical injury* (known in common law as *battery and assault*), e.g., when the physician performs procedures without the patient's consent or the consent is invalid; (2) *false imprisonment and wrongful commitment*, e.g., detention in a hospital for failure to pay hospital bills; (3) *infliction of mental distress*; (4) *unauthorized communications and disclosure*, which may come in the form of defamation (e.g. false imputation of certain diseases to another); invasion of privacy (e.g. permitting other persons to have contact or access to the patient, and publicity of plaintiff's private life); and divulgence of confidential information.[34]

An advantage of an action based on intentional torts as opposed to negligence actions is that expert evidence may be dispensed with because it is not necessary to establish a standard of care. Moreover, an action may lie purely for harm to dignity without any physical harm. However, as the name intentional torts implies, the element of "intent" must be proved.[35]

In the cases of *Salen v. Balce*[36] and *Fuellas v. Cadano*,[37] it appears that article 2176 (though technically limited to negligence cases) may extend to cases of *intentional* malpractice. In any case, it is also possible to base such an action for intentional tort on the Human Relations provisions of the Civil Code, namely,

> *Article 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.
>
> *Article 20.* Every person who, contrary to law, **willfully or negligently** causes damage to another, shall indemnify the latter for the same.
>
> *Article 21.* Any person who **willfully** 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.

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[33] JOSEPH H. KING, JR., THE LAW ON MEDICAL MALPRACTICE, 179 (2d ed., 1986) [hereinafter KING] (Some of these torts, such as battery and assault, are American law concepts and may not be exactly applicable in Philippine cases).

[34] *Ibid.*

[35] *Ibid.*

[36] G.R. No. 14414, April 27, 1980, 107 Phil. 748. "While we agree with the theory that, as a rule, the civil liability arising from a crime shall be governed by the provisions of the Revised Penal Code, we disagree with the contention that the subsidiary liability of persons for (the) acts of those who are under their custody should likewise be governed by the same Code even in the absence of any provision governing the case for that would leave the transgression of certain rights without any punishment or sanction in law. Such would be the case if we uphold the theory of appellee as sustained by the trial court."

[37] G.R. No. 14409, October 31, 1961, 3 SCRA 361.

Article 19 lays down the principle of *abuse of right*. While article 19 does not provide for indemnity for damage arising from the improper exercise of a right, it is complemented by the rules in articles 20 and 21, which clearly provides for indemnification. In article 20, the act may either be *willfully or negligently* done, while in Article 21 the loss or injury must have been *willfully* caused.[38] Also, abuse of right is actionable under Article 20 if it is *contrary to law*, or under article 21, if it is *contrary to morals, good customs or public policy*.[39] Given that all acts or omissions causing damage or injury to another are either contrary to law, or to morals, good customs or public policy, no conceivable wrong would escape liability under these three articles. Taken together, they provide for actionable wrong for all harmful acts or conduct.[40]

In medical malpractice, the Human Relations provisions may be used for *intentional* malpractice,[41] since articles 20 and 21 clearly cover cases where damage is caused "willfully." These legal provisions may thus be used where article 2176 (quasi-delict) is not applicable.

c. Separate Civil Action for Liability Arising from Crime

Certain acts of medical malpractice may be prosecuted as crimes under the Revised Penal Code (Section B, *infra*). Thus, a doctor may have injured (or even killed) his patient for which he may be held criminally liable for physical injuries or homicide. Under article 100 of the Revised Penal Code, "every person criminally liable for a felony is also civilly liable." Thus, if an act of medical malpractice is also a crime under the RPC, the injured party may institute a separate civil action to recover damages for the civil liability which arose from the crime.[42] Such civil action for liability arising from crime is generally suspended by the criminal prosecution,[43] but there are certain cases where the Civil Code (article 33) allows an

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[38] CEZAR SANGCO, 1 TORTS AND DAMAGES 749 (1994).

[39] Velayo v. Shell, 54 O.G. No (1), 63; Philippine National Bank v. Court of Appeals, 83 SCRA 237; Globe Mackay Cable and Radio Corp. v. Court of Appeals, 176 SCRA 778.

[40] *Id.*

[41] "In the Philippines the counterpart of intentional torts are those specific torts contained in scattered provisions of the Civil Code, particularly in the Chapter of Human Relations (see Arts. 19-36); that of negligence actions are quasi-delict (Art. 2176 et seq.) and those of strict liability are those provided in Art. 2180 and others which regulate acts committed by persons for whom another is made responsible by law..." CARMELO SISON, PHILIPPINE LAW ON TORTS, NOTES AND CASES 2 (1986).

[42] RULES OF COURT, Rule 111, sec. 1 (a) (Generally, the civil action for the recovery of civil liability arising from an offense is "deemed instituted" with the criminal action, unless the offended party waives the civil action, reserves the right to institute it separately or institutes the civil action prior to the criminal action).

[43] RULES OF COURT, Rule 111, sec. 2.

"independent civil action" which shall proceed independently of the criminal prosecution (not suspended), and shall require only a preponderance of evidence. Such "independent civil action" is allowed in cases of "defamation, fraud, and physical injuries."[44]

d. Civil Action Based on Breach of Contract

Though rare, it is possible for medical malpractice liability to arise from contracts.[45] It is rare because doctors do not usually guarantee success or specific results, recognizing the inherent uncertainty in the practice of medicine. But it is possible to base a medical malpractice action on contractual liability when a physician not only undertakes to perform in accordance with the applicable standard of care, but also promises to do something more,[46] such as (a) produce a specific therapeutic result; (b) employ a specific technique, e.g., normal delivery instead of caesarean section;[47] (c) perform specific services for the patient.[48] In such a case, the victim of medical malpractice may then file a civil action based on breach of contract, instead of torts.

Contracts promising specific results are the most common source of medical malpractice litigation based on contract, but it is not without controversy. Some believe that holding a physician liable for failing to produce a specific result could be unwise, in light of the inherent uncertainty of the practice of medicine. Moreover, the physician could just be offering therapeutic reassurances to his patient. There is also a tendency of patient fraud (this problem may be solved by including such contracts specifying results within the coverage of the statute of frauds.)[49]

The advantage of a contract action is that negligence (including standard of care and causation, which ordinarily require an expert witness) need not be proved. All that the plaintiff has to prove is the existence of the contract, its terms and its breach by the defendant doctor, and the damages incurred.

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[44] *See Carandang vs. Santiago,* G.R. No. 8238, May 25, 1955, 97 Phil. 94 (The defamation, fraud, and physical injuries mentioned in this article are used not in the sense defined in the Revised Penal Code, but in their generic sense).

[45] *See* Christ v. Lipsitz, 160 Cal. Rptr. 498 (Cal.App., 1979). *See also* TIERNEY, *Contractual Aspects of Malpractice*, 19 WAYNE L.REV. 1457, 1478 (1973).

[46] KING, *op. cit. supra* note 33, at 253 ff.

[47] *See* Stewart v. Rudner, 84 N.W.2d 816 (Mich. 1957).

[48] KING, *op. cit. supra* note 33, at 253 ff.

[49] *See, e.g.*, Ind. Code Ann. Sec. 16-9.5-1-4 (1983).

2. Criminal Remedy

Our penal laws do not punish or criminalize medical negligence *per se*. However, the Revised Penal Code (RPC) penalizes criminal negligence in general as a *quasi-offense*,[50] and in fact, this provision has been used to criminally prosecute negligent physicians.[51] Under article 365 of the RPC, any person such as a physician, who, by reckless imprudence or by simple imprudence or negligence, shall commit an act which, had it been intentional, would constitute a felony (like homicide or physical injuries), shall suffer a penalty of imprisonment.

Of course, other felonies under the RPC, such as homicide,[52] murder,[53] infanticide,[54] mutilation,[55] physical injuries,[56] are also applicable to rare cases, where the necessary elements are present, of physicians *intentionally* inflicting injury on their patients.

More applicable to doctors are the RPC provisions penalizing *abortion*[57] and giving *assistance to suicide*.[58] However, even in these areas, there are still some unresolved issues and ambiguities. For instance, in *abortion*, can a doctor be held criminally liable for performing an abortion which is deemed necessary to save the life of the mother? Under its present wording, the RPC does not provide for exceptions; however, the Constitution provides that the State "shall equally protect the life of the mother and the life of the unborn from conception."[59] In *giving assistance to suicide*, does such crime contemplate withdrawal of life-support systems to a patient, not yet clinically dead, where the use of such apparatus has already become futile in the opinion of qualified medical personnel?[60]

Moreover, there are scattered provisions under special laws penalizing other forms of medical malpractice, such as the following:

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[50] REVISED PENAL CODE, art. 365.

[51] *See e.g.*, Cruz v. Court of Appeals, G.R. No. 122445, November 18, 1997.

[52] REVISED PENAL CODE, art. 249.

[53] REVISED PENAL CODE, art. 248.

[54] REVISED PENAL CODE, art. 255.

[55] REVISED PENAL CODE, art. 262.

[56] REVISED PENAL CODE, arts. 263-266.

[57] REVISED PENAL CODE, art. 259 in relation to art. 256.

[58] REVISED PENAL CODE, art. 253.

[59] CONST., art. II, sec. 12. See also Summerfield v. Superior Court, 698 P.2d 712 (Ariz., 1985), on the physician's dual duty of care to the fetus and the pregnant mother.

[60] See Barber v. Superior Court, 195 Cal. Rptr. 484 (Cal.App. 2 Dist., 1983) where the omission to continue treatment was held not an unlawful failure to perform a legal duty.

a.) Illegal practice of medicine (under Sec. 10 in relation to Secs. 8 & 28 of The Medical Act of 1959 [61]);
b.) Demanding "any deposit or any other form of advance payment for confinement or treatment... in emergency or serious cases" (under B.P. Blg. 702);
c.) Failure by the attending physician who has treated a person for serious or less serious physical injuries to report promptly the fact of such treatment to the nearest government health authority (under P.D. No. 169, as amended by E.O. No. 212).

For patients and victims of medical malpractice, the advantage of criminal prosecution, with its threat of incarceration, is its greater deterrent effect, and the free services provided by the public prosecutor handling the criminal case. However, proof "beyond reasonable doubt" is required to convict an accused, which is more difficult to establish. Often, the same proof which suffices to establish civil liability is inadequate to criminally convict an accused.[62]

3. Administrative Remedy

A victim of medical malpractice can also seek recourse against the erring physician from the administrative agencies regulating the medical profession. He can file an administrative complaint against a doctor for "gross negligence, ignorance or incompetence" with the Board of Medical Examiners, with a right to appeal to the Professional Regulatory Commission.

The Professional Regulation Commission (PRC), created by P.D. 223, is the agency charged with supervision, licensing, and regulation over various professions, including medicine.[63] Moreover, it is given the power to review and approve the policies, resolutions, rules and regulations, orders, or decisions promulgated by the various professional boards.[64] The PRC is the administrative agency where decisions of the Board of Medicine regarding medical malpractice may be appealed.[65]

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[61] Rep. Act No. 2382 (1959).

[62] *See, e.g.* Cruz v. Court of Appeals, G.R. No. 122445, November 18, 1997, (dismissing the criminal case for reckless imprudence resulting in homicide because of reasonable doubt, but at the same time, ordering accused to pay damages, holding that the same evidence is sufficient for the purpose of establishing the civil case.)

[63] Pres. Decree No. 223 (1973), sec. 3.

[64] Pres. Decree No. 223 (1973), sec. 5 (b).

[65] Pres. Decree No. 223 (1973), sec. 5 (c).

In medicine, the professional board in charge is the Board of Medical Examiners (created by R.A. No. 2382). Aside from its responsibility over matters pertaining to examinations for admission into the medical profession, the Board of Medical Examiners is also tasked with the conduct of administrative investigations for violations of the law and the rules committed by doctors in the practice of their profession.[66] After due investigation, the Board may reprimand erring physicians, suspend, or revoke registration certificates, if the respondent is found guilty.[67]

Section 24 of R.A. No. 2382 enumerates the grounds for reprimand, suspension, or revocation.[68] Perhaps the most applicable ground for medical malpractice is paragraph (5): "Gross negligence, ignorance or incompetence in the practice of his or her profession resulting in an injury or death of the patient." Section 24 also includes as a ground any "violation of any provision of the Code of Ethics as approved by the Philippine Medical Association."[69] The Code of Ethics for Physicians referred to provides for the duties of physicians to the community, to their colleagues and the profession, and to other professionals. The physician's duty to his patients includes the imperative to attend to emergencies, to seek assistance in difficult cases, to the exercise of good faith and confidentiality, and to charge only reasonable fees.

An administrative case is commenced by filing a written complaint under oath by any person, or by the Board itself, *motu proprio*.[70] The respondent then files an answer, and chooses between a formal investigation of the charges against him

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[66] Rep. Act No. 2382 (1959), sec 22.

[67] R.ep. Act No. 2382 (1959), sec 22.

[68] Sec. 24. Grounds for reprimand, suspension or revocation of registration certificate.

(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 name, profession, limitation of practice, clinic hours, 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;

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

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

[69] Rep. Act No. 2382 (1959), sec. 24, par. (12).

[70] Rules and Regulations Governing the Regulation and Practice of Professionals, art. IV, sec. 2.

or having the case decided on the pleadings.[71] If the respondent chooses the former, a trial-type proceeding commences. The respondent also enjoys the right to be heard in person or by counsel, to a speedy and public hearing, to cross-examine adverse witnesses, and to all rights granted under the Constitution and the Rules of Court.[72] Moreover, according to the case of *Pascual v. Board of Medical Examiners*,[73] recognizing the applicability of the right of the accused against self-incrimination, the respondent cannot be compelled to testify in such a proceeding.

The Board *en banc* shall then resolve the case by majority vote. The parties may appeal the decision to the PRC within thirty (30) days from receipt of the decision,[74] and later to the Office of the President.[75]

Two years after revocation of registration, in case such penalty was imposed, the Board may order reinstatement if the respondent has acted in an exemplary manner in his community of residence and if he has not committed any illegal, immoral, or dishonorable act.[76]

III. A CRITIQUE OF THE PRESENT LEGISLATIVE PROPOSALS

There is an impression that the remedies currently available are inadequate. Thus, our lawmakers have come up with several legislative bills to address the problem of medical malpractice. In this section, we shall analyze and evaluate those legislative proposals currently pending in Congress, based on effectiveness, feasibility, innovativeness, scope, coherence, and consistency.

A. HOUSE BILL NO. 4955[77]

Perhaps the crudest legislative proposal, introduced by Rep. Oscar Rodriguea, is House Bill No. 4955, which seeks to *criminalize* medical malpractice and provide stiffer penalties therefor. H. B. No. 4955 provides that "any medical practitioner who performs any act constituting medical malpractice or the illegal malpractice of surgery shall be punishable by imprisonment or fine or both and, in all instances, the cancellation of the license to practice medicine" (sec. 4).

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[71] Rules and Regulations Governing the Regulation and Practice of Professionals, art. IV, sec. 2.
[72] Rules and Regulations Governing the Regulation and Practice of Professionals, art. IV, sec. 25.
[73] 28 SCRA 345 (1969).
[74] Pres. Decree No. 223 (1973), sec. 6.
[75] Rep. Act No. 2382 (1959), sec. 26.
[76] Rep. Act No. 2382 (1959), sec. 27.
[77] H No. 4955, 12th Cong. 2nd Sess. (2002).

The term "*malpractice*" is defined therein as "any personal injury, including death, caused by the negligent or wrongful act or omission of any medical practitioner" (sec. 3 [3]). Under the said bill, medical malpractice is punishable by "*prision mayor* and the cancellation of the license and a fine ranging from Five Hundred Thousand Pesos (P500,000.00) to One Million Pesos (P1,000,000.00) in the discretion of the court, taking into consideration all attendant circumstances" (sec. 7).[78]

There are several infirmities in the proposed law.

First, the measure is of doubtful constitutionality. It is violative of the equal protection clause,[79] as it discriminates against a class of persons – physicians. A certain class of persons is being singled out and punished more severely for negligence in the practice of their profession. Indeed, "the guaranty of the equal protection of the laws is not violated by a legislation based on reasonable classification,"[80] but is there a "reasonable classification" in this case? To meet the reasonable classification test, the classification "must rest on substantial distinctions."[81] It might be argued that doctors are in a peculiar position because they are entrusted with the lives of their patients and their negligence could spell the difference between life and death. But one may pose the counterargument that there are also other professions or occupations where negligence might be dangerous or fatal, e.g., a reckless driver of a public utility vehicle, an incompetent engineer of a shoddy building, or even a defense lawyer in a criminal case. Common carriers have a duty to observe "extraordinary diligence" for the safety of their passengers,[82] but their negligence is not *specifically* penalized[83] with draconian penalties. One must also remember that the constitutional challenge is particularly stronger in this case since the proposed law is penal in nature, thus the Supreme Court would be stricter in reviewing this law (if enacted).

Second, the proposed bill might also be violative of substantive due process. The crime of medical malpractice is vaguely defined in House Bill No. 4955 as "any personal injury, including death, caused by the negligent or wrongful act or

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[78] The shoddy draftsmanship of H.B. No. 4955 is worth noting: while section 4 thereof provides that medical malpractice is punishable by "imprisonment *or* fine *or* both" (alternative penalties), section 7 of the same bill provides for a penalty of "prision mayor and the cancellation of the license to practice the medical profession *and* a fine..." (cumulative penalties), thus resulting in an inconsistency.

[79] CONST., art. III, sec. 1.

[80] People v. Cayat, 68 Phil. 12, 18 (1939).

[81] *Id.*

[82] CIVIL CODE, art. 1733.

[83] They are penalized generally for criminal negligence under Article 365 of the Revised Penal Code.

omission of any medical practitioner." There is not even an attempt to define the crucial element of "negligent or wrongful act or omission," which is unpardonable for a criminal statute. In contrast, the Revised Penal Code defines reckless imprudence[84] and simple imprudence.[85] Even the Civil Code provides its own definition of negligence.[86]

Moreover, the penalty (*prision* mayor and fine of P500,000.00 to P1,000,000) seems excessive for certain offenses that may fall under the bill's overbroad definition of medical malpractice.[87] This anomaly is largely due to the fact that said House Bill does not discriminate between the less serious injuries and the more serious ones. Thus a doctor faces the possibility of being imprisoned or fined for as trivial an injury as a clipped toenail or singed hair.[88]

Third, criminalization of medical malpractice may not even be necessary, because our law already penalizes criminal negligence in general as a quasi-offense under article 365 of the Revised Penal Code. In fact, this provision is actually being used to criminally prosecute negligent physicians.[89] A new law punishing medical negligence is therefore redundant.

Fourth, the bill's effectiveness as a deterrent against medical malpractice is doubtful – its only touted innovation is that it provides for increased penalties. House Bill No. 4955 provides for a penalty of *prision mayor*,[90] while under article 365 of the Revised Penal Code, the highest penalty possible is *prision correccional* in its

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[84] REV. PEN. CODE, art. 365. "Reckless imprudence consists in voluntarily, but without malice, doing or failing to do an act from which material damage results by reason of inexcusable lack of precaution on the part of the person performing or failing to perform such act, taking into consideration his employment or occupation, degree of intelligence, physical condition and other circumstances regarding persons, time and place."

[85] REV. PEN. CODE, art. 365. "Simple imprudence consists in the lack of precaution displayed in those cases in which the damage impending to be caused is not immediate nor the danger clearly manifest."

[86] CIVIL CODE, art. 1173. "The fault or negligence of the obligor consists in the omission of that diligence which is required by the nature of the obligation and corresponds with the circumstances of the persons, of the time and of the place."

[87] Isagani A. Cruz, *The Medical Malpractice Bill*, The Philippine Daily Inquirer, August. 24, 2002, at p. 6, col. 2. "Section 20 of the Bill of Rights clearly and expressly provides that 'excessive fines shall not be imposed.' Even at the current peso exchange rate, the amount of from P500,000 to P1,000,000 cannot be considered peanuts; it is unquestionably excessive by any standard. Moreover, the due process clause requires equivalence between the offense and the penalty, unlike under the bill in question, where the fine can be as high as a million pesos. It is like punishing jaywalking with life imprisonment."

[88] Although section 7 of H.B. No. 4955 gives the court a certain amount of discretion in fixing the fine, "taking into consideration all attending circumstances," still, the minimum fine would be five hundred thousand pesos (P500,000.00) – a hefty amount if the injury suffered is not so serious.

[89] *See, e.g.*, Catillo v. People, G.R. No. 86890, January 21, 1994, 229 SCRA 386 (1994); Cruz v. Court of Appeals, G.R. No. 122445, November 18, 1997.

[90] 6 years and 1 day to 12 years.

medium period.[91] But deterrence of medical negligence, like any crime or other wrongful conduct, is not as simple as increasing the penalties. Such a solution would be as crude as Hammurabi's law in ancient Babylon which punished erring physicians by cutting off their hands.[92] One doctor likened it to "using a shotgun to kill a fly on a patient's forehead."[93]

It is too simplistic to think that criminalizing medical malpractice will achieve its avowed purpose of stimulating care in doctors and deterring them from behaving negligently. Increasing the penalties for medical negligence may appear at first glance to be effective in deterring deleterious behavior. However, it must be considered that deterrence rests on the assumption that there was "contemplation of criminal behavior, awareness of the sanction, and its avoidance on grounds of self-interest."[94] These assumptions do not exist in negligence.[95] If the medical practitioner thought about his behavior in relation to the proscribed harm, then he cannot be said to be negligent. "The punishment of inadvertent harm-doers can not be justified on the ground that it stimulates care by other persons... [o]n the contrary, recent psychological testing indicates rather definitely that it is unproductive of care or efficiency in the persons punished."[96]

Fifth, criminalizing medical malpractice may have undesirable repercussions. "[L]aws which make certain types of behavior criminal may be more undesirable in their social consequences than the behavior itself."[97] In this case, one "undesirable social consequence" of criminalizing medical malpractice is the probable increase in the cost of health care system as a result of "defensive medicine," which refers to medical practices in which physicians engage merely for the purpose of avoiding malpractice suits, or for the purpose of providing a defense in case a suit is filed.[98] Defensive medicine could lead to unnecessary waste when the physician performs additional (more than necessary) tests or procedures in order to avoid being accused of negligence. The doctor might also unreasonably avoid procedures perceived as legally risky, to the detriment of the patient.[99] Increased health care costs would also result due to higher premiums for malpractice insurance.

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[91] 4 years, 9 months and 11 days to 5 years, 4 months and 20 days.

[92] ENCYCLOPAEDIA BRITANNICA, Vol. 11, p. 823, (15th ed.).

[93] Philip S. Chua, M.D., *Malpractice Bill: Malady Masquerading As Cure*, The Philippine Daily Inquirer, November 23, 2002.

[94] JEROME HALL, GENERAL PRINCIPLES OF CRIMINAL LAW 244 (1947).

[95] *Id.*, at 245.

[96] *Ibid.*

[97] MICHAEL AND ADLER, CRIME. LAW AND SOCIETY, in FRED INBAN AND CLAUDE SOWLE, CRIMINAL JUSTICE, CASES AND COMMENTS 15-16 (1964).

[98] THOMAS, *supra* note 3, at 498.

[99] *Ibid.*

There is also a danger that criminalization of medical malpractice might deter not just malpractice or negligence but also the practice of medicine itself. According to the Position Paper of the University of the Philippines-Manila:

> [The proposed bill] will further deplete the ranks of doctors and health professionals as they will shy away from providing health care because of the "criminal implications" of their slightest errors and the stiff penalties that will be imposed on them. The risks and implications on their career as well as the possible financial burdens will encourage selective treatment of patients. It will also discourage health professionals from conducting free medical missions for indigent patients and providing free treatments for those working in government hospitals. The bill will further drive many health practitioners to practice abroad because of higher benefits and better legal protections.[100]

Sixth, criminalizing medical malpractice and providing more severe penalties would not solve an even bigger problem – how to prove or establish a case of medical malpractice. This is a crucial problem, a *sine qua non* to the effectiveness of the deterrent effect of the legislative proposal. For what is the use of a crime in the statute books if the prosecution cannot get a conviction for failure to prove the crime? Many injured victims of medical malpractice and their lawyers complain that it is difficult to prove and win a medical malpractice case – largely because of the lack of willing expert witnesses from the ranks of the medical profession. But if a *civil case* is already very difficult to prosecute and establish, what more for a *criminal case*, where the law requires a higher burden of proof (beyond reasonable doubt). In fact, in many cases, a doctor is held civilly liable for malpractice but is acquitted of reckless imprudence, precisely because the evidence necessary for civil liability is usually insufficient for a criminal conviction.[101] The proposed bill totally ignores this problem of proving a malpractice case and thus, may end up being a dead statute.

B. SENATE BILLS

There are generally two classes of the proposed laws affecting medical malpractice. The first class (S.B. Nos. 2303 and 2298) criminalizes medical

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[100] Consolidated Position Paper of the University of the Philippines Manila on the Proposed Medical Malpractice Bill Submitted to the Senate and the House Committee on Health by U.P. Manila Chancellor Marita V.T. Reyes, M.D. *Forum*, January 28, 2003, p. 2.

[101] *See* Cruz v. Court of Appeals, G.R. No. 122445, November 18, 1997, (dismissing criminal case because of reasonable doubt, but holding that the same evidence is sufficient for the purpose of establishing the civil case).

malpractice. The second class (S.B. Nos. 808, 2235, and 2359) does not specifically mention the term "medical malpractice," but enumerates and defines certain rights granted to patients, as well as imposes penalties for violations thereof. We include them in this discussion because, in the broader sense of malpractice, violations of these patients' rights constitute medical malpractice.

1. Senate Bills Criminalizing Medical Malpractice

The two Senate bills, S.B. Nos. 2303 and 2298, and the House version, H.B. No. 4955 (discussed *supra*) are triplets separated at birth. Their similarity is uncanny as can be read from the policy, definitions, punishable acts, and penalties. They therefore have the same infirmities and shortcomings found in H.B. No. 4955.

Like in H.B. No. 4955, S.B. No. 2303 (introduced by Sen. Noli de Castro) crudely defines malpractice as "any injury, including death, caused upon the patient and arising from the negligent or wrongful act or omission of any medical practitioner or similar health care provider." S.B. No. 2298 (introduced by Sen. Manuel Villar) provides a similar definition. Both bills are silent as to the definition or scope of injury. The injury could very well be a minor bleeding as a result of an erroneous insertion of an intravenous needle.

S.B. 2303 enumerates, albeit not exhaustively, acts that constitute medical malpractice. Section 4 thereof provides:

> Section 4. *Medical Malpractice.* – The negligence in medical malpractice cases can occur in a variety of situations including but not limited to:
> a) Failure to provide emergency medical services;
> b) Failure to diagnose a disease;
> c) A surgical or anesthesia related mishap during an operative procedure;
> d) Failure to gain the informed consent of the patient for an operation or surgical procedure;
> e) A physician who has made the correct diagnosis, but thereafter fails to properly treat the disease process; and
> f) Misuse of prescription drugs or a medical device or implant.

Penalizing the first malpractice act listed is *perhaps* acceptable, since it is limited to emergency situations. The French Penal Code has a similar provision,

although it applies to all persons in general, not just to doctors.[102] However, the law should be clear in providing the exception that doctors may refrain from giving assistance if there is a threat to their lives or their safety, as indicated in another law.[103]

The wisdom behind the second malpractice act is suspect because no doctor can completely guaranty the accuracy of a diagnosis or a non-diagnosis. Penalizing such a failure will predictably result in an extreme form of *defensive medicine* where a doctor would much rather make a diagnosis that lacks adequate basis, rather than missing an illness, no matter how farfetched based on the symptoms. Such approach would be needlessly expensive and wasteful.

The third item seems to classify surgeons and anesthesiologists as distinct from other medical practitioners. Their singling out is constitutionally questionable since no substantial difference is offered for their "special" treatment. In addition, the definition of a "mishap" is vague and overbroad.

Failure to get informed consent before an operation or surgical procedure is indeed reprehensible and should perhaps be criminalized. However, the definition for "informed consent" is not well crafted.[104]

As for the fifth item, "failure to properly treat the disease" that was correctly diagnosed, it is very broad and does not specify what is meant by "proper" treatment. It may lead to the implication that an unsuccessful treatment is not proper and therefore punishable. This is extremely unwise, since the practice of medicine is not an exact science. The same criticism may be raised against the sixth item – "misuse of prescription drugs or a medical device or implant"; the word "misuse" is not defined.

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[102] FRENCH PENAL CODE, Art. 63, par. 2, which states: "Anyone, who willfully abstains from giving help to a person in danger, when he could so help him, without danger to himself or others, either by his own action or by calling for help, shall be punished with imprisonment of from three months to five years and with a fine of from 360-15,000 Francs, or to only one of these penalties."

[103] THE MEDICAL ACT OF 1959, Rep. Act No. 2382, sec. 24, provides: "Grounds for reprimand, suspension or revocation of registration certificate. xxx. Refusal of a physician to attend to 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."

[104] As provided in S.B. 2303, informed consent refers to "the process undergone by the medical practitioner, whether through written or oral communication, of informing the patient before performing a procedure, prescribing a drug, or taking significant action; in particular refers to medical practitioners' requirement to inform the patient of the projected effectiveness of his or her treatment and the possibility of negative side effects or adverse outcomes."

As for the penalties, both bills provide for imprisonment of *prision mayor* and the cancellation of the license to practice the medical profession. A fine ranging from P500,000 to P1,000,000 is also provided, but in the De Castro version, the fine will only be imposed if the violator is a "health care provider."[105] Like in the House version, such penalties are excessive, especially since the law does not specify the degrees and gradations of injury.

In addition to the penalties already mentioned, the bills also grant the courts the power to revoke or to cancel the license to practice for the offenders. This is quite objectionable since it might emasculate the Professional Regulatory Commission and the Board of Medical Examiners of its power to revoke or cancel licenses. Such a provision runs contrary to the rationale for establishing specialized agencies which are in the best position to make factual findings and impose corresponding penalties in highly technical cases.

2. Senate Bills on Patients' Rights

Senate Bills Nos. 808, 2235, and 2359 are in the nature of *magna carta* of patients' rights, some of which are already existing under present laws while others are new. The said bills also provide penalties, lighter than those in the malpractice bills, for violations thereof. Senate Bills No. 808 (Sen. Oreta), No. 2235 (Sen. Villar), and No. 2539 (Sen. Flavier) are almost similar in providing the following basic rights:

a. *"Right to Medical Care and Humane Treatment"* – Each person has the right to *good* medical care. Each of the bills provide that if a person cannot be given immediate treatment that is medically necessary, he shall be informed of the reason for the delay and/or referred for treatment elsewhere. The right to be admitted without need for any deposit, pledge, mortgage, or any security is also protected. The version of Sen. Flavier wisely adds the proviso that the patient and/or his relatives have the obligation to pay for the treatment extended.

b. *"Right to Informed Consent"* – This is basically the right to a clear explanation of all the procedures to be taken, and the clarification of all the risks involved. If the consent of the patient or the guardian to a medically necessary procedure cannot be obtained, the physician or any interested person can petition the court to give an order giving approval.

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[105] "Health Care Provider" is defined in S.B. No. 2303 as referring to "any institution licensed by appropriate regulatory agency to provide professional standard of medical care such as but not limited to Health Maintenance Organizations (HMOs), managed care organizations and hospitals." (sec. 3b).

c. *"Right to Privacy"* – The right to be left alone is not absolute, however. The various exceptions in the bills include considerations of waiver, public health and safety, controversies including capacity to decide, requirements of law, and study of the case for medical forum. The right to confidentiality is included.

d. *"Right to Information"* – The patient has the right to be informed on all matters involving his or her treatment, subject to the exception that information may be withheld if it would be detrimental to his or her health. In such cases, the information can be withheld until a future time that is more appropriate.

e. *"Right to Choose Physician"* – This right is limited if the patient is confined to a charity ward, in cases of waiver, or if he has contracted with a health maintenance organization or health insurance provider where it was agreed that only physicians connected with the institution are allowed.

f. *"Right to Self Determination"* – The right to self-determination is the freedom of the patient to refuse treatment and certain procedures. However, certain requisites must concur—he must be of age and sound mind, informed of the consequences of such a refusal, he must release his health care giver from liability, and such a decision will not affect public health or safety. The issuance of advance directives is included in this right.

g. *"Right to Religious Belief"* –The bills acknowledge that certain religions prohibit some procedures to be done on their followers. As such, the right to refuse certain treatments for being contrary to their beliefs is respected. However, such right will not be imposed on minor children (below 18 years of age) because they cannot decide for themselves.

h. *"Right to Leave"* – The patient may leave the hospital, subject to the conditions in the sixth enumerated right hereof. This right subsists notwithstanding any liabilities to the hospital. This provision makes sense because detention of a patient is clearly repugnant to his constitutional right to liberty.

i. *"Right to Refuse Participation in Medical Research"* – This right may only be waived in writing. However, it is submitted that this right must be limited in cases where the patient is in a charity ward or a teaching hospital.

j. *"Right to Choose Pharmacy"* – A patient has the freedom to choose where to buy prescribed medicine and other medical needs.

k. *"Right to Correspondence and to Receive Visitors"* – The right may only be regulated within reasonable rules by the health care institution.

l. *"Right to Express Grievances"* – To strengthen this right, the bills make it imperative for the Department of Health to establish a grievance machinery in consultation with health care professionals and other concerned agencies and parties.

These Senate bills on patients' rights are sound and beneficial. Although many of the rights can probably be derived from our present laws on the right to privacy and self-determination, it is still much better to specify these rights for better enforceability and to eliminate confusion; such specification is also a pre-requisite in making their violation punishable.

However, these patients' rights are just a portion of medical malpractice law. There are still many aspects of malpractice law that are not dealt with, especially on negligence. Although our Civil Code treats these matters in general, it does not specifically resolve certain issues and problems specific to medical malpractice and does not shed light on certain grey areas. In other words, all these bills, even when taken together, are *not systematic and comprehensive enough* in dealing with the subject of medical malpractice. Such limitation is precisely what we seek to address in our "modest proposal."

IV. A MODEST PROPOSAL

In the Philippines, only a few malpractice suits are filed and won. This is the problem which our lawmakers want to address through the various legislative bills they filed, which aim to protect the rights of patients against malpractice. As previously discussed, these legislative bills suffer from certain defects. House Bill No. 4955 criminalizing medical malpractice is a crude and draconian response and is open to serious constitutional doubts. The Senate Patients' Rights bills, meanwhile, show a more progressive approach; however, they are not comprehensive enough, leaving many areas of medical malpractice law still unresolved.

A more meaningful reform in medical malpractice laws is needed. Such reform should achieve two important goals – adequate *compensation* for the victim, and *deterrence* to negligent physicians.

Adequate compensation does not only mean giving new rights to patient-victims; it also means improving the remedies available to enforce those rights. The remedies should be clear, effective, and accessible.

Another goal for policymaker is deterrence. But deterrence is just the flipside of effective remedies for the victims. If plaintiff-victims have effective remedies at their disposal, if they can establish their case as well as obtain compensation from defendant-physicians – doctors will surely take notice and be more careful. If there emerges a trend of malpractice victims winning cases and negligent doctors being held accountable, the medical profession will surely heed the warning and be careful; nobody likes to be haled to court and pay damages.

In our opinion, what is needed is not so much a drastic reform but a "**fine-tuning**" of our laws on torts and evidence so as to make it easier for a malpractice victim to establish his case and obtain compensation for his injuries, thereby also deterring negligent physicians. In our **tort law**, reforms should be in the form of a *comprehensive* and *systematic* statement of our medical malpractice tort law, through a statute. The provisions therein need not be always new and pioneering; in most instances, they may be derived from other tort rules and principles already existing. The goal is to make our medical malpractice law clearer and more definite. As for our **law of evidence**, reforms should come in the form of facilitating the plaintiff's efforts to establish his case, largely though some fine-tuning of the crucial expert witness requirement.

A. LAW OF TORTS

The current remedy of malpractice victims is mainly a tort action, specifically negligence torts or quasi-delicts.[106] Generally, our present tort system is quite adequate as a remedy for victims of medical malpractice seeking redress. Concepts and principles of American tort law (standard of care, causation, contributory negligence, vicarious liability, defenses, etc.) used to successfully prosecute malpractice cases are similar to Philippine tort law concepts and principles, which is due to the common-law origins of a large part of Philippine tort law.

What is needed is merely to "**fine-tune**" our law of medical malpractice, through a statute laying down a *comprehensive and systematic statement* of our law on medical malpractice, a "complete legislative statement of the whole body of the law (on medical malpractice) so as to put it authoritatively in one self-sufficing form."[107]

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[106] For the difference between quasi-delicts and other forms of torts, *see* ANTONIO T. CARPIO, *Intentional Torts in Philippine Law*, 47 PHIL. L. J. 649, 649-50 (1972).

[107] ROSCOE POUND, SOURCES AND FORMS OF LAW, in HORACE READ, *et al.*, CASES AND OTHER MATERIALS ON LEGISLATION 233 (1959). The process of enacting such "legislative statement" may be called *codification*, but we shall refer to our proposed law as a medical malpractice *statute* instead of a *code*, because the

Although we propose a comprehensive and systematic statement of our medical malpractice law, we say it is merely fine-tuning because many of the rules that will be included in such law already exist in our current civil law.

The medical malpractice statute would do four things:

(a) restate current rules (laws and jurisprudence) on negligence, making them more specifically applicable to medical negligence
E.g., - restate the rules on the effect of contributory negligence on the liability of the physician;

(b) clarify our rules in areas where the law is not very clear
E.g., - formulate an appropriate standard of care;

(c) amend certain laws and harmonize those rules which are in conflict or controversy
E.g., the accrual of cause of action in the computation of prescription period;
the applicability of the "captain-of-the-ship" doctrine;[108]
the vicarious liability of the hospital for the negligence of the doctor;[109]

(d) provide rules in areas which are not covered or contemplated by our current law, so that "legislation can by way of anticipation make rules for cases that have not yet arisen,"[110]

E.g., - validity of "advance directives";[111]

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law of medical malpractice is just a part of our civil law. *See also* TOLENTINO, I COMMENTARIES ON THE CIVIL CODE 218 (1987).

[108] "Under this doctrine, the surgeon is likened to a ship captain who must not only be responsible for the safety of the crew but also of the passengers of the vessel. The head surgeon is made responsible for everything that goes wrong within the four corners of the operating room. It enunciates the liability of the surgeon not only for the wrongful acts of those who are under his physical control but also those wherein he has extension of control." Ramos v. Court of Appeals, G.R. 124354, December 29, 1999, 321 SCRA 584 (1999). This doctrine was applied in *Ramos* even if it is no longer used in the U.S. because it is not realistic to expect the lead surgeon to have control over matters within the expertise of other physicians, like the anesthesiologist, *see* Thompson v. Presbyterian Hospital, Inc., 652 P.2d 260 (Okl., 1982).

[109] See Ramos v. Court of Appeals, G.R. No. 124354, April 11, 2002, 380 SCRA 467 (2002), where the Supreme Court absolved the hospital from liability for the negligence of a doctor who acts merely as a "consultant" and not an employee. But this doctrine may conflict with the principle that the hospital may be held liable as principal because the doctor may be considered as its *ostensible agent* if the hospital caused the patient to assume that there is an agency relationship between them, *see* Jacoves v. United Merchandising Corp., 9 Cal. App. 4th 88, (Cal.App.2.Dist., 1992), and Mduba v. Benedictine Hospital, 52 A.D.2d 450 (N.Y.A.D., 1976).

[110] SIR JOHN SALMOND, JURISPRUDENCE § 51 (8th ed., 1930).

- authority of the parent or guardian refuse blood transfusion for his child or ward on religious grounds.

A comprehensive and adequate medical malpractice statute should, first of all, lay down the basic principles of medical malpractice law, beginning with its elements: "duty, breach, injury and proximate causation."[112] A medical malpractice action has the following elements: (1) a *duty* of care was owed by the physician to the patient; (2) the physician violated the applicable *standard of care*; (3) the plaintiff suffered a *compensable injury*; and, (4) such injury was *caused in fact* and *proximately caused* by the substandard conduct.[113]

The benefit of such a statute would be twofold: (a) educational and (b) promotional.

A statute on medical malpractice would *educate* the bench and the bar on tort law concepts and principles that may be unclear, uncertain, or confusing, aside from introducing new rules peculiar to medical malpractice law. Right now, there are only about half a dozen medical malpractice cases decided by the Supreme Court[114] and a few more reported Court of Appeals cases,[115] usually citing American authorities; thus, there is very little guidance on the matter. Such a malpractice statute would also educate the medical profession on the conduct expected of them and the responsibilities imposed on them. Lastly, such a medical malpractice statute would educate the public, particularly the patients, about their rights and remedies when they become unfortunate victims of medical negligence.

Intertwined with the educational effects of such a statute would be its *promotional* effects. "Promotional" is used here, for lack of a better term, in the sense of encouraging victims of medical malpractice to avail of the remedies given to them by the law. Merely being informed of their rights as patients would already be a big boost to victim-patients' sense of empowerment. Often, the reluctance of

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[111] "Advance Directive" is a document executed by a person of age and of sound mind, which directs health care providers to refrain from providing prolonged life support when the situation arises that the person executing such directive suffers a condition with no hope of reasonable recovery.

[112] Garcia-Rueda v. Pascasio, G.R. No. 118141, September 5, 1997, 278 SCRA 769 (1997).

[113] KING, *op. cit. supra* note 33, at 9.

[114] Carillo v. People, 229 SCRA 386 (1994); Batiquin v. Court of Appeals, 258 SCRA 334 (1996); Garcia-Rueda v. Pascasio, 278 SCRA 769 (1997); Cruz v. Court of Appeals, G.R. No. 122445, November 18, 1997; Reyes v. Sisters of Mercy Hospital, 341 SCRA 760 (2000); Ramos v. Court of Appeals, 321 SCRA 584 (1999), 380 SCRA 467 (2002).

[115] Abaya v. Favis, 3 C.A. Rpt. 2d 450 (1963); Jusay v. Genato, 4 C.A. Rpt. 2d 593 (1963); Chan Lugay v. St. Luke's Hospital, Inc., 10 C.A. Rpt. 2d 415 (1960); Bernal v. Alonso, 12 C.A. Rpt. 2d 792 (1967); Morales v. Mary Johnston Hospital, Inc., 15 C.A. Rpt. 2d 28 (1970);

victim-patients to sue negligent doctors is the result of their ignorance of their legal rights and remedies.

Codifying the rules and principles of medical malpractice law would also prevent judicial legislation, which is not only unconstitutional but also could lead to chaos and confusion in the state of the law. Thus we could avoid what happened in the United States about two decades ago, when the courts (not the legislatures) began to make changes in the law of medical malpractice, which generally had the effect of expanding the liability of doctors.[116]

1. Subjects that Must Be Covered By a Medical Malpractice Statute

For such a medical malpractice statute to be systematic and comprehensive, the rules on each of the following areas should be laid down by Congress:

a. Duty

The statute should begin with a statement that it is the duty of an attending physician to use reasonable skill and care for the safety and well-being of his patient,[117] and that this duty does not necessarily arise from contract (such that a physician-patient relationship may arise even if it was a third party, e.g., an employer who hired the services of the physician),[118] and that a physician-patient relationship may arise even if the services are gratuitous.[119]

The statute should then clarify the duration of this duty and hold the physician liable for abandonment of the patient. Although a physician has a right to withdraw from a case, he is bound first to give due notice to the patient and afford the latter ample opportunity to secure other medical attendance of his own choice.[120] What constitutes reasonable notice will depend on the condition of the patient and the availability of other suitable medical care.[121]

The statute should also clarify the physician's duty to persons with which he has non-therapeutic medical relationship, such as when a physician examines insurance applicants; claimants for personal injury, disability and medical benefits;

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[116] KING, *op. cit. supra* note 33, at 319.

[117] *See* Hill v. Stewart, 209 So. 2d 809 (Miss. 1968).

[118] *See* Du Bois v. Decker, 29 N.E. 313 (N.Y. 1891).

[119] *Ibid.*

[120] Bolles v. Kinton, 263 P. 26 (Colo. 1928); Carroll v. Griffin, 101 S.E.2d 764 (Ga.App. 1958)..

[121] KING, *op. cit. supra* note 33, at 23.

applicants for employment; and of prospective employees.

b. Standard of Care

A very crucial area of medical malpractice law is the standard of care. The proposed statute would not be complete without a sufficient formula for the standard of care applicable to medical malpractice cases. The formula adopted by the Supreme Court (citing American authorities) in the cases of *Garcia-Rueda v. Pascasio*[122] and *Cruz v. Court of Appeals*,[123] is a good starting point:

> [Doctors] have a duty to use at least the same level of care that any other reasonably competent doctor would use to treat a condition under the same circumstances. 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.

It would be better, however, if the statute will also include the factors that a court should consider in determining the appropriate standard of care, which would provide a nice balance between definiteness and flexibility. Examples of those factors are indicated in the so called *Blair* formulation,

> [A physician is] under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances...
>
> Locality is merely one factor to be taken into account in applying general professional standards... [t]he standard should be established by the medical profession itself and not by lay courts... [t]he evidence may include the elements of locality, availability of facilities, specialization or general practice, proximity of specialists and special facilities as well as other relevant considerations.[124]

There are many controversies that could arise in the determination of the proper standard of care alone. For instance, should the standard of care refer to the "acceptable practice" or the "customary practice" of physicians?[125] "Customary practice" (usual or typical conduct) has been the traditional rule, although some critics fear that this rule might condone substandard customs. "Acceptable practice" is the alternative. These are medical practices approved by the profession and expected of its members. The reasonable expectations and collective sense of

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[122] G.R. No. 118141, September 5, 1997, 278 SCRA 769 (1997).

[123] G.R. No. 122445, November 18, 1997.

[124] Blair v. Eblen, 461 S.W.2d 370, 373 (1970), *cited in* KING, *op. cit. supra* note 33,at 42. *See also* Titchnell v. U.S., 681 F.2d 165; Daniels v. Gilbreath, 668 F.2d 477 (laying out other standards).

members of the profession (and not merely medical custom) as to what constitutes sound medicine would be the controlling inquiry.[126] "The customary practice standard looks to the historical conduct of the profession whereas the accepted standard approach would focus on the best standards of the day."[127]

The medical malpractice statute should aid the courts in evaluating the appropriate standard of care by laying down "frames of reference"[128] — relevant factors that a court should consider in determining the applicable standard of care. For instance a court should consider (a) the time of the act or omission complained of; (b) the defendant's situation (professionally) and (c) the geographic frame of reference.

The geographic frame of reference is particularly contentious. The traditional rule is the "strict locality rule" where the courts merely look at the professional standards in the particular locality where the negligence occurred.[129] The courts later on realized the disadvantages of the "strict locality rule" — it lowers the standard of care; it limits the pool of available witnesses; and it disregards the trend of increasing uniformity in the practice of medicine.[130] Thus, the better rule would be to treat the local standards as not conclusive but only one of several relevant factors,[131] recognizing that "now there is no lack of opportunity for a physician or surgeon to keep abreast of the advances made in his profession and to be familiar with the latest methods and practices."[132]

Thus, the question posed before our lawmakers is whether we should adhere to the traditional "strict locality" rule, or apply a national standard of care, such as in England.[133] They should be well aware of the dangers and disadvantage of a "strict locality" rule and at the same time, they must consider the reality that in the Philippines, there is indeed a great disparity between medical care in far-flung rural communities and that in more advanced urban areas.

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[125] KING, *op. cit. supra* note 33, at 44.

[126] *Id* at 72-73.

[127] CUSTODIO O. PARLADE, *Physician's Liability: For the Lawyers*, in MEDICINE AND THE LAW: PROCEEDINGS OF THE SYMPOSIUM ON CURRENT ISSUES COMMON TO MEDICINE AND LAW [hereinafter MEDICINE AND THE LAW] 24 (U.P. Law Center, 1980).

[128] KING, *op. cit. supra* note 33, at 55.

[129] Hemingway v. Ochsner Clinic, 608 F.2d 544; McCurdy v. Hatfield, 183 P.2d 269.

[130] KING, *op. cit. supra* note 33, at 59.

[131] *See* McGulpin v. Bessmer, 43 NW 2d 121; Tallbull v. Whitney, 564 P.2d 162; Vassor v. Roussalis, 658 P.2d 1284; King v. Williams, 279 SE 2d 618.

[132] Pederron v. Dumouchel, 431 P2d 933 (1967), cited in PARLADE 23. *See also, Note: An Evaluation of Changes in the Medical Standard of Care*, 23 VANDERBILT L.R. 729 (1970).

[133] PARLADE, *supra* note 127, at 24.

Both here[134] and in the U.S.,[135] that expert testimony is generally required to establish the applicable standard of care. Such requirement will be more extensively discussed in the later part of this paper.

c. Causation

Another element of medical negligence is the causal connection between the malpractice and the plaintiff's injuries,[136] that is, that the malpractice is the *proximate cause*[137] of the injury. Unless falling within the "common knowledge" of laymen, causation (like standard of care) must be proved by expert testimony.[138] An expert's testimony would be sufficient to support a finding of causation if he stated that he had formed an opinion *with reasonable medical certainty* that the alleged tortious conduct *more likely than* not was a cause of the harm.[139] It is not essential that the negligence is "necessarily an *exclusive* cause of death."[140] The Supreme Court recognized that "the concept of causation in general, and of the cause of death in human beings in particular, are complex and difficult notions. What is fairly clear is that death,... is preceded by a series of physiological events, any one of which events can, with equal cogency, be described as a 'cause of death' "[141]

d. Contributory Negligence

Our present tort law is already quite clear on the effect of the patient's own negligence on the liability of the physician. The medical malpractice statute can simply restate the rules laid down in article 2179 of the Civil Code, thus:

> *Art. 2179.* When the plaintiff's own negligence was the immediate and proximate cause of his injury, he cannot recover damages. But if his negligence was only contributory, the immediate and proximate cause of the injury being the defendant's lack of due care, the plaintiff may recover damages, but the courts shall mitigate the damages to be awarded.

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[134] *See* Garcia-Rueda v. Pascasio, 278 SCRA 769 (1997); Reyes v. Sisters of Mercy, 341 SCRA 760, 769-770 (2000).

[135] KING, *op. cit. supra* note 33, at 52.

[136] Hurley v. Johnston, 122 A.2d 732 (Conn. 1956).

[137] Proximate cause is "that cause which, in a natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury and without which the result would not have occurred." Vda. de Bataclan v. Medina, 102 Phil. 181.

[138] KING, *op. cit. supra* note 33, at 200.

[139] *Id*, at 201.

[140] Carillo v. People, G.R. No. 86890, January 21, 1994, 229 SCRA 386, 395 (1994).

[141] *Id.*, at 394.

Thus, if the plaintiff's own negligence was the "immediate and proximate cause of his injury" – as when he refused to refused to submit to proper treatment[142] or failed to follow instructions[143] or failed to return to the doctor as instructed[144] – the physician is not liable. However, if the patient's negligence is merely *contributory* (e.g., if the patient's fault is subsequent to that of the physician and merely aggravated the injury inflicted by the physician[145]), it will not bar recovery of damages but will only mitigate damages.

e. Informed Consent

Another very important area in medical malpractice is the doctrine of "*informed consent*," based on the patient's *right to self-determination*. This right was first enunciated in an early case by Justice Cardozo: "[E]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[146] This doctrine is also intimately linked with a person's constitutional right to privacy.[147] Some of the Senate Bills on Patients' Rights (SB Nos. 808, 2235, and 2359) currently pending and discussed above (Sec III-B) also deal, quite extensively, with certain rights relating to informed consent.

The general rule is that a patient's consent, express or implied, is a prerequisite of any medical treatment or procedure, and an operation without the patient's consent would render the physician or surgeon liable in damages.[148] The usual exception is in case of emergency when it is impracticable to obtain his consent.[149]

The consent given by a patient must be an *informed consent*. Before a patient undergoes a medical procedure he must first receive the necessary information about it, especially concerning its inherent risks.[150] For a surgical operation, the physician must disclose the following matters: (1) diagnosis or nature of the illness;[151] (2) description of the proposed procedure;[152] (3) material risks or dangers

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[142] *See* Newell v. Corres, 466 N.E.2d 1085.

[143] *See* Gerber v. Day, 6 P.2d 535.

[144] *See* Ries v. Reinard, 117 P.2d 386.

[145] *See* Leadingham v. Hillman, 5 S.W.2d 1044.

[146] Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (1914); *See* Harbeson v. Parke Davis, Inc., 476 F.2d 517;

Salis v. U.S., 522 F.Supp. 989; Niblack v. U.S., 438 F.Supp. 383.

[147] *See* PETER RIGA, *Informed Consent*, 10 LINCOLN LAW REV. 159 (1970), cited in GEORGE EUFEMIO, *Informed Consent to Medical Treatment (For the Doctors)* [hereinafter EUFEMIO], in MEDICINE AND THE LAW, *supra* note 127, at 65.

[148] Wall v. Brim, 138 F.2d 478 (C.A.5 1943).

[149] Wheeler v. Barker, 208 P.2d 68 (Cal.App. 2 Dist.1 1949).

[150] KING, *op. cit. supra* note 33, at 155.

[151] *See* Haley v. U.S., 739 F.2d 1502.

involved;[153] (4) benefits of the proposed procedure;[154] and (5) alternative methods of management.[155]

The problem usually arises in the determination of the applicable standards of disclosure. In the U.S., the majority rule is that the extent of a physician's duty to disclose is determined by professional standards.[156] However, some cases[157] adhere to the "reasonable lay person standard," also known as "materiality standard."[158] Under this rule, professional standards are not conclusive. A physician must disclose all *material* risks, and risks are deemed material when a reasonable person in the patient's position would likely attach significance to them in deciding whether or not to proceed with the proposed therapy.[159]

Mere proof of violation of a duty to disclose does not entitle one to recover unless plaintiff also proves causation. The plaintiff has to prove also that the non-disclosure is "outcome-determinative" to the patient's decision to proceed with the medical procedure, i.e., had he known the risk he would not have consented to the procedure.[160]

As to *form*, a patient's consent to a medical procedure may be express or implied.[161] A more problematic area would be the *scope* of a patient's consent, i.e., whether the medical procedure actually performed on the patient was within the scope of that patient's consent. Generally, a physician has no right to extend the scope of an operation or other medical procedure without the patient's consent. In some urgent circumstances, however, consent to extension is implied.[162]

When the patient is not competent to consent because of age or mental incapacity, substituted consent by a parent or guardian is usually required.[163] A medical malpractice statute should clarify the limits of this authority to consent for another (child or ward). For instance, may the surrogate (or even the courts) consent to a procedure that is not designed primarily for the benefit of the patient

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[152] *See* Marino v. Ballestas, 749 P.2d 162.

[153] *See* Haley v. U.S., 739 F.2d 1502.

[154] *See* Henderson v. Milobsky, 595 F.2d 654.

[155] *See* Petty v. U.S., 740 F.2d 1428.

[156] *See* Wheeldon v. Madison, 374 N.W.2d 367; Guebard v. Jabaay, 452 N.E.2d 751.

[157] *See* Canterbury v. Spence, 464 F.2d 772, 783 (1972).

[158] EUFEMIO, *supra* note 147, at 70-71.

[159] Crain v. Allison, 443 A.2d 558.

[160] Goldstein v. Kelleher, 728 F.2d 32.

[161] AMADO S. TOLENTINO, JR., *Informed Consent to Medical Treatment (For the Lawyers)*, in MEDICINE AND THE LAW, *supra* note 127, at 89.

[162] *Id*, at 90, *citing* Delahunt v. Flinton, 221 N.W.2d 168 (1978).

[163] *See* Zoski v. Gaines, 260 N.W. 99.

(such as donation of an organ for transplant to another)? In one case,[164] an American state court upheld the authorization of the lower court for the transplant of kidney from a mentally retarded minor to his brother, under the circumstances that the risk to the retarded donor was slight while the potential benefit to him was great due to his close relationship with his brother.

On the reverse side, there are important questions on *refusal* to give consent to treatment. Generally, a person has the right to refuse treatment. But this has limitations, such as in compulsory vaccination, or if the refusal (say, blood transfusion) amounts to suicide. The problem becomes more difficult when it is the parent or guardian who refuses treatment. For instance, can a parent or guardian refuse a life-saving blood transfusion for its child or ward, on ground of religious reasons? Even in the U.S., the authorities are divided on this question.[165] There is also the issue of whether the guardian or the family can consent to the withdrawal of life-support system of a patient in comatose and a vegetative state, which has been resolved in the affirmative by U.S. courts.[166]

The statute should provide some guidelines and safeguards (such as the requirement of an "advance directive"[167]) for delicate issues like these, which are literally matters of life and death. Although they must be decided by a judge using his discretion and taking all relevant factors into consideration, there must be some guidance from Congress, balancing between individual freedom and social considerations.[168]

f. Confidentiality and Wrongful Disclosure

The relation between a physician and his patient is one of trust and confidence and the physician has the duty to act in utmost good faith.[169] Part of this relation of trust and confidence is the physician's duty not to disclose privileged communications or information about his patient. This duty of non-disclosure is recognized not only by the Code of Medical Ethics, but also by the Rules of Court, thus,

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[164] Strunk v. Strunk, 445 S.W.2d 145 (1969).

[165] KING, *op. cit. supra* note 33, at 147.

[166] The pioneering case on this matter is *In re* Quinlan, 429 U.S. 922 (1976).

[167] *Advance Directive* is a "duly notarized document executed by a person of age and of sound mind, which directs health care providers to refrain from providing prolonged life support when the situation arises that the person executing such directive suffers a condition with no hope of reasonable recovery." S. No. 808, 12th Cong., 2nd Sess. (2002), Sec. 3 (1).

[168] KING, *op. cit. supra* note 33, at 146-47.

[169] Campbell v. Oliva, 424 F.2d 1244.

> *Rule 130, Sec. 24 (c)* A person authorized to practice medicine, surgery or obstetrics cannot, in a civil case, without the consent of the patient, be examined as to any advice or treatment given by him or any information which he may have acquired in attending such patient in a professional capacity, which information was necessary to enable him to act in that capacity, and which would blacken the reputation of the patient.

A physician can be held liable for damages to his patient for injuries resulting from a wrongful disclosure of confidential information, whether on the witness stand[170] or elsewhere,[171] as an actionable invasion of the patient's right to privacy.[172] But this rule is qualified by the physician's duty to the public in certain circumstances, and it is wise if the medical malpractice statute would clarify these exceptions. For instance, if the patient is afflicted with an infectious or highly contagious disease (such as AIDS), it may be the physician's duty to disclose its existence to the public health authorities or even to particular individuals intimately exposed to the danger of contagion.[173] Senate Bill No. 808 attempts to define these exceptions as follows:

> (a) when his/her mental or physical condition is in controversy in a court litigation and the court in its discretion orders him/her to submit to a physical or mental examination by a physician;
> (b) when the public health and safety so demand;
> (c) when the patient or, in his/her incapacity, his/her legal surrogate, expressly waives this right;
> (d) when it is otherwise required by law; and
> (e) when his/her medical or surgical condition, without revealing his/her identity, is discussed in a medical or scientific forum for expert discussion for his/her benefit and for the advancement of science and medicine.[174]

It would be better, however, if paragraph (b) above is clarified and made more specific. In what instances can "public health and safety" warrant disclosure of the patients' secrets? Who determines the demands of "public health and safety"?

g. Vicarious Liability

The statute should also clarify who are the persons who may be held *vicariously liable* for medical malpractice, and to what extent. Under current

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[170] Pyramid Life Insurance Co. v. Masonic Hospital Association, 191 F. Supp. 51.
[171] Simenson v. Swenson, 177 N.W. 831.
[172] Hammonds v. Aetna Casualty & Surety Co. 243 F.Supp. 793.
[173] Simenson v. Swenson, 177 N.W. 831.
[174] S. No. 808, 12th Cong., 2nd Sess. (2002), Sec. 4 (3).

Philippine tort law, employers are vicariously liable for the damages caused by their employees acting within the scope of their assigned tasks.[175] Similarly, in the U.S., a lead surgeon may be held liable for the negligence of the nurse assisting him in the operation where the relation of master-servant exists between them.[176] He may also be held liable for the negligence of other hospital employees who act as his "temporary servants" or "borrowed servants" during an operation,[177] although a qualification must be made that the surgeon is not liable for purely "administrative" tasks, such as cleaning the operating room, placing clean sheets on the operating table, preparing gowns and gloves, sterilizing the instruments, etc.[178]

Ordinarily, a physician will not be vicariously liable for the conduct of another physician merely because they have both been involved in the care of the same patient independently,[179] or when the defendant merely referred the patient.[180] But there are exceptions, *e.g.*, when one physician is actually the employee of another physician, exercising over him the requisite degree of control. Another important exception is when one physician is held to be a "borrowed servant" of another physician. But courts are now usually reluctant to apply the borrowed servant rule.[181] Given the increasing complexity and modernization in surgery and medical procedures, it is not realistic to expect that the lead surgeon will have control over matters within the expertise of other physicians, like the anesthesiologist.[182]

However, in the recent case of *Ramos v. Court of Appeals*,[183] the Philippine Supreme Court, applying the "captain-of-the-ship" doctrine,[184] held the surgeon liable for the negligence of the anesthesiologist under certain conditions. In that

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[175] CIVIL CODE, art. 2180.

[176] Aderhold v. Bishop, 221 P. 752

[177] Ybarra v. Spangard, 154 P.2d 687; McKinney v. Tromly, 386 S.W.2d 564.

[178] Benedict v. Bani, 122 A.2d 209.

[179] Doran v. Priddy, 534 F.Supp. 30

[180] Mincey v. Blando, 655 S.W.2d 609. (*Note*, however, that even if not vicariously liable, the physician may still be held liable *directly*, e.g., recommending another physician whom he knows is incompetent, or, in case of two or more physicians actively participating in the care of the patient, failing to warn the other physician that the latter is following a course inconsistent with sound medical practice. *See* KING, *op. cit. supra* note 33, at 235).

[181] KING, *op. cit. supra* note 33, at 248. According to VICENTE FRANCISCO (AGENCY 289-295, *citing* MANRESA and MECHEM), a principal is liable for the delicts and quasi-delicts of his agent done within the scope of authority.

[182] Thompson v. Presbyterian Hospital, Inc., 652 P.2d 260.

[183] 321 SCRA 584 (1999); 380 SCRA 467 (2002).

[184] "Under this doctrine, the surgeon is likened to a ship captain who must not only be responsible for the safety of the crew but also of the passengers of the vessel. The head surgeon is made responsible for everything that goes wrong within the four corners of the operating room. It enunciates the liability of the surgeon not only for the wrongful acts of those who are under his physical control but also those wherein he has extension of control." Ramos v. Court of Appeals, 321 SCRA 584, 619 fn. 73 (1999).

case, even if the surgeon did not actually exercise control over the anesthesiologist, the Supreme Court took into consideration the fact that it was the surgeon who recommended the anesthesiologist and that the two "worked as a *team*"[185] and that "they have a common responsibility to treat the patient, which responsibility necessitates that they call each other's attention to the condition of the patient while the other physician is performing the necessary medical procedures."[186]

The hospital remains vicariously liable *together* with the physician if the latter is the hospital's employee[187] or if he is an *actual* or *ostensible* agent of the hospital.[188] An ostensible agency is established when a principal intentionally, or by want of ordinary care, causes a third person to believe another is an agent.[189] When a hospital holds out a physician as an employee, a patient may reasonably assume that the physician is an employee of the hospital without making an inquiry on the subject.[190]

A hospital is generally not *vicariously* liable for the negligence of non-employee physicians who merely exercise hospital or so-called "staff privileges."[191] Thus, in the same case of *Ramos v. Court of Appeals*,[192] the Court absolved the hospital from the liability of the surgeon and anesthesiologist, where the latter were not considered as employees but merely accredited "consultants" exercising the privileges of maintaining a clinic in the hospital and using the facilities of the hospital. [193] The hospital's obligation was limited to the provision of equipment and facilities and services of the hospital staff and the doctor-patient contract (fee

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[185] 380 SCRA 467, 491 (2002).

[186] 380 SCRA 467, 495-6 (2002).

[187] CIVIL CODE, art. 2180. In the case of *Barredo v. Garcia*, 73 Phil. 607, the Supreme Court held that an employer can be civilly liable for quasi-delict (hence directly liable), even if his employee has already been found criminally negligent for the same act. This is significant in medical malpractice cases where the act or omission is already covered by a penal statute in the sense that the patient is given more options in recovering damages. A patient can institute a civil action for quasi-delict against hospital-employer of the doctor, as allowed by Article 2180 of the new Civil Code, while a criminal action proceeds against the latter, subject to Article 2177, which prohibits a plaintiff from recovering damages twice. The advantage of an action for quasi-delict is that the hospital-employer may be made directly liable, instead of subsidiary (which is the case for liability governed by the Revised Penal Code).

[188] KING, *op. cit. supra* note 33, at 250.

[189] Jacoves v. United Merchandising Corp., 9 Cal. App. 4th 88, 11 Cal. Rptr. 2d 468 (1992), and *Mduba v. Benedictine Hospital*, 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976).

[190] Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955).

[191] KING, *op. cit. supra* note 33, at 299. In most hospitals there are two classes of physician staff members – those merely holding staff privileges and those who are actual employees of the hospital. Interns and residents are among the most common examples of the latter.

[192] 321 SCRA 584 (1999); 380 SCRA 467 (2002).

[193] 380 SCRA 467, 500 (2002).

for the doctor's services) is separate and distinct from the hospital-patient contract (fee for the use of the facilities and staff services).[194]

It should also be noted that the hospital may also be held *directly* liable. Five basic obligations have most commonly been relied upon to support a claim founded on the corporate liability of a hospital in connection with the delivery of hospital services:[195] (1) hospital equipment, supplies, medication and food; (2) hospital environment; (3) safety procedures; (4) selection and retention of employees and conferral of staff privileges; and (5) responsibilities for supervision of patient care.

h. Amount of Damages

To prevent abuse and to alleviate the concern of the medical community, the statute may perhaps provide for "damage caps" or limitations on the amount of *non-economic damages* (moral and exemplary damages) recoverable.[196] Such statutory provisions are quite usual in many American states, to control the discretion of juries which are wont to award huge awards to piteous plaintiffs, causing increased insurance costs for doctors. In many jurisdictions, such "damage caps" have been held valid and constitutional, surviving challenges based on due process and equal protection.[197]

For awards exceeding a certain threshold limit, the judge might also be given the discretion to order periodic payments to ease the burden.[198]

i. Statute of Limitations

The statute should also clarify the issue of prescription of a medical malpractice action, or statute of limitations. The four-year prescription period for tort actions under the Civil Code,[199] may be adopted, although for medical malpractice cases, a clarification is still needed for the proper interpretation of the "*accrual of the cause of action*," which is the start of the prescription period.[200]

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[194] *Id.*

[195] *Id.* at 307-315.

[196] *E.g.*, CALIFORNIA CIVIL CODE § 3333.2. In the case of Ramos v. Court of Appeals, 380 SCRA 467 (2002), the Supreme Court ordered the defendant surgeon and anesthesiologist to pay P 2,000,000 in moral damages and P 100,000 in exemplary damages.

[197] Hoffman v. U.S., 767 F.2d 1431; Johnson v. St. Vincent Hospital, Inc. 404 N.E.2d 685.

[198] *E.g.*, CALIFORNIA CIVIL PROCEDURE CODE § 667.7

[199] CIVIL CODE, art. 1146 (2).

[200] Under article 1150 of the Civil Code, "the time for prescription... shall be counted from the day they may be brought," or from the time of the accrual of cause of action, since at that time, there is

The traditional rule is to consider the accrual from the date of commission of the *wrongful conduct*.[201] But a better rule, at least for medical malpractice cases, is to consider the accrual of the period from the time the plaintiff *discovers* or reasonably should have discovered his injury.[202] This is particularly important in cases of foreign objects left inside the body of a patient after surgery, which may not be discovered until several years after the operation [203] A compromise might come in the form of a hybrid rule prescribing a period counted from the date of discovery, but in no case more than a longer period of time from the date of injury.[204] The medical malpractice statute might also wisely provide that the running of the statute of limitations is suspended during the pendency of a continuing involvement between the doctor and the patient, because a patient is justified in not suing a doctor who is still treating him.[205]

j. Other Matters

Perhaps it would also be wise to incorporate a "Good Samaritan" provision which would limit a physician's liability for medical care rendered at an emergency, subject to the qualification that the physician is acting in good faith and the negligence is limited to ordinary negligence.[206] Also, the medical services must be gratuitous and rendered at the scene of an accident or emergency and usually does not extend to emergency services at a hospital or physician's office.[207]

Our lawmakers might also want to address certain knotty reproductive problems, such as a "*wrongful pregnancy*" action, wherein a physician is negligent in performing a sterilization procedure (tubal ligation or vasectomy) and as a consequence, the woman conceives a child which is unplanned.[208] In the U.S., traditionally, no recovery is allowed because pregnancy and childbirth are considered blessed events.[209] However, there is a trend there now that negligent sterilization and subsequent childbirth may give rise to actionable injury and

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already a *legal possibility* of bringing the action. TOLENTINO, 4 COMMENTARIES ON THE CIVIL CODE 43 (1987). Espanol vs. Chairman, Philippine Veterans Administration, 137 SCRA 314 (1985).

[201] Paulan v. Sarabia, G.R. No. L-10542, July 31, 1958; Escueta v. Fandialan, G.R. No.L-39675, Nov. 29, 1974; Kramer v. Court of Appeals, G.R. No. L-83524, Oct. 13, 1989.

[202] Zeidler v. U.S., 601 F.2d 527.

[203] Baughman v. Bolinger, 485 F.Supp. 1000.

[204] *Similar to* CALIFORNIA CIVIL PROCEDURE CODE § 340.5 (West 1992).

[205] KING, *op. cit. supra* note 33, at 276.

[206] McKenna v. Cedars of Lebanon Hospital, 155 Cal. Rptr. 631.

[207] Colby v. Schwartz, 144 Cal. Rptr. 631.

[208] James v. Caserta, 332 S.E.2d 872.

[209] Abbariao v. Blumenthal, 483 NY.S.2d 296.

damages attending unwanted pregnancy, including pain and suffering, medical expenses, lost income, even lost consortium.[210]

Similarly difficult is a *"wrongful birth"* action, wherein the physician negligently fails to inform the parents of the increased possibility that the mother would give birth to a child suffering from birth defects, thereby precluding an informed decision about whether to have a child and resulting in the birth of a child with defects or disabilities.[211] These actions are recognized in some American states.

B. LAW OF EVIDENCE

Negligence, including medical negligence, is not presumed but must be affirmatively proved.[212] Medical malpractice cases are "singularly beset with problems of proof."[213] Proving the elements of the cause of action may be quite tricky, largely because of the requirement of an expert witness, who may not always be available to the plaintiff. Thus, a medical malpractice statute should also include clarifications and some modifications of our law of evidence.[214] Such new rules of evidence (supplementing and modifying the Rules of Court) would focus on the proofs necessary to establish two essential elements of negligence in medical malpractice cases: standard of care and causation.

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[210] Fulton-De Kalb Hosp. Authority v. Graves, 314 S.E.2d 653.

[211] Procanik v. Cillo, 478 A.2d 755.

[212] TOLENTINO, 5 COMMENTARIES ON THE CIVIL CODE 601 (1992), *citing* Barcelo v. Manila Electric, 29 Phil. 351; Cea v. Villanueva, 18 Phil. 538; Molina v. De la Riva, 32 Phil. 277; *etc.*

[213] JOHN FLEMING, *Developments in the English Law of Medical Liability*, in THOMAS G. ROADY AND WILLIAM ANDERSEN, eds., PROFESSIONAL NEGLIGENCE 97, at 110 (1960).

[214] According to the present Constitution, Art. VIII, Sec. 5 (5), the Supreme Court has the power to "promulgate rules concerning... pleading, practice, and procedure in all courts." The provision in the 1935 and 1973 Constitutions that the Rules of Court may be "repealed, altered or supplemented" by Congress has not been retained in the 1987 Constitution, leading some to believe that the Supreme Court now has the exclusive authority over Rules of Court. However, according to constitutionalist Joaquin Bernas, that it is understood that Congress has the "equally inherent power... to legislate on matters of court procedure." BERNAS, THE 1987 CONSTITUTION: A COMMENTARY 871 (1996). Also, according to Prof. Antonio Bautista, "Congress of course retains the plenary power to legislate on pleading, practice and procedure and the investiture of this power in the Supreme Court has not displaced the legislature's co-existing authority on the matter." BAUTISTA, BASIC CIVIL PROCEDURE 2 (2003).

1. Standard of Care

Usually, the testimony of expert witnesses is required to prove the standard of care in medical malpractice cases.[215] *Expert Witness* refers to "a person qualified to speak authoritatively on a subject by reason of special training, skill or familiarity with the subject and gives or expresses opinion on the matter which is in accordance with what he believes or infers as regards the facts in dispute as distinguished from his personal knowledge of the fact itself. His testimony is better known as 'Opinion Evidence,' in contradistinction to the testimony of an ordinary witness who testifies on matters which are of his own personal knowledge."[216]

This requirement is a source of frustration for plaintiffs and their counsels who find it difficult to procure doctors or medical experts to serve as witness. According to Arsenio C. Pascual, Jr., a lawyer-physician, "Doctors do not only shy away from the rigors of being a witness but actually go to great extents, even to the point of risking being cited in contempt of court for failure to obey subpoenas, in their effort to avoid court appearances."[217] One authority[218] explained this "marked reluctance on the part of medical professionals... to testify against each other," sometimes referred to as "conspiracy of silence," as attributable to a number of factors:

> Preparation for and appearance in legal proceedings is time-consuming and diverts time away from one's practice. Some physicians fear retaliation by insurers or colleagues if they testify. There is concern about loss of referrals or staff privileges and about a willingness of the other physician to testify against the expert if he is ever sued. Others decline to testify out of a sense of professional loyalty.[219]

There are some ways by which a medical malpractice statute could alleviate this difficulty. Perhaps the statute could make the plaintiff's search for an expert easier by laying down the rules on who may be considered expert witness in medical malpractice cases and how to establish the competency of expert witness. Congress should clarify if only a *specialist* can testify as expert witness, in light of the ruling in the case of *Reyes v. Sisters of Mercy*,[220] where the Supreme Court discarded the testimony of a physician (a "chief pathologist") on typhoid fever, because he is

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[215] Garcia-Rueda v. Pascasio, 278 SCRA 769 (1997); Reyes v. Sisters of Mercy, 341 SCRA 760, 769-770 (2000).

[216] ARSENIO C. PASCUAL, JR., *Physicians as Expert Witnesses (For the Doctors)*, in MEDICINE AND THE LAW, *supra*, at 117.

[217] *Id.* at 118.

[218] KING, *op. cit. supra* note 33, at 76.

[219] *Id.* at 76-77.

[220] 341 SCRA 760 (2000).

not a specialist on infectious diseases.[221] (The same over-reliance on specialists is expressed in *Ramos v. Court of Appeals*.[222]) The Supreme Court probably came to this conclusion because the non-specialist's testimony was pitted against the testimony of a specialist. Even so, taken as a *general* rule, this is quite a restrictive view, especially when compared to the rule in the U.S. where an expert witness need not always be a specialist. What is required of an expert witness is general experience and adequate familiarity with the medical procedures and the medical condition involved [223] An otherwise competent physician will not *automatically* be excluded in an action against a specialist simply because the witness is a general practitioner or a member of another specialty (or vice versa).[224] The fact that the witness is a general practitioner testifying against an expert in the field of the latter's medical specialty affects only the *weight* but not the *admissibility* of the testimony.[225]

More importantly, the statute should provide for **exceptions** to the expert witness requirement, to address the problems of the unwillingness of competent experts to testify against other practitioners coupled with the expenses of retaining an expert,[226] thereby removing the need for an expert witness altogether. Some of these exceptions need to be included in the law to erase any doubts of inconsistencies with the regular rules of evidence.

a. *Common Knowledge Situations*.[227] In non-technical situations, when the alleged negligence is comprehensible to laymen without the guidance of expert evidence, expert testimony will not be required to prove a violation of the standard of care.[228] The necessity of expert witness may be dispensed with if the negligence of the physician is so grossly apparent or the treatment is such a common occurrence that a layman would have no difficulty in appraising it.[229] The judge is then allowed to rely on his common knowledge to evaluate the defendant's conduct, and arrive at the appropriate standard of care. This exception usually applies when surgical sponges and other foreign object are inadvertently left in the patient's body after surgery[230] or when a physician has injured parts of the body which

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[221] *Id*, at 773.

[222] 321 SCRA 584 (1999).

[223] KING, *op. cit. supra* note 33, at 78, see cases cited therein.

[224] *See* Greene v. Thomas, 662 P.2d 491 (1982) (dicta); Taylor v. Hill, 464 A.2d 938 (1983).

[225] Carbore v. Warburton, 94 A2d 680 (1953).

[226] KING, *op. cit. supra* note 33, at 83.

[227] LaRoche v. U.S., 730 F.2d 538. KING, at 84. *See examples and cases.*

[228] Ramos v. Court of Appeals, 321 SCRA 584 (1999); Reyes v. Sisters of Mercy Hospital, 341 SCRA 760, 770..

[229] Newman v. Spellberg, 234 N.E.2d 152.

[230] Conrad v. J. Kewood Gen. Hospital, 410 P.2d 785 (1966); Young v. Fishback, 262 F.2d 469 (1958); Moore v. Ivoy, 264 S.W. 283 (1924).

were not diseased or under treatment.[231] It frequently operates with *res ipsa loquitur*, but not always.[232]

b. *Defendant's Admissions and Testimony.* Admissions,[233] even extrajudicial ones, have the same legal competency as direct expert testimony to establish the allegations of the complaint, provided it is an admission of lack of skill or negligence, and not merely an admission of a bona fide mistake of judgment.[234] Such evidence may be in the form of extrajudicial statements, pleadings, pre-trial discovery, or testimony at trial.

c. *Manufacturer's Instruction and Information* (Package Inserts, and Physician's Desk Reference or PDR).[235] The statute should clarify the *admissibility* of this type of evidence, in light of the rules on hearsay. They might be objected to as hearsay because the persons who prepared them cannot be cross-examined. However, they may be admissible as exceptions to the hearsay rule, analogous to "commercial lists and the like."[236] They would also be non-hearsay if introduced for some purpose other than proving the truth of the statement, such as proving information that the defendant knew or should have known. Manufacturer's information and recommendations should be admissible when relevant.[237] However, the defendant should be free to explain his departure from the manufacturer's recommendations or to show why such recommendations are not applicable or should not preclude a finding that he followed an acceptable course of action.

d. *Medical Literature* could also qualify as exception to the hearsay rule as "learned treatises,"[238] although medical literature as evidence is much less reliable than manufacturer's instructions.[239] The Supreme Court, however, seems to be receptive to such type of evidence. In the case of *Carillo v.*

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[231] Stuckleman v. Synhorst, 52 N.W.2d 504.

[232] Ramos v. Court of Appeals, 321 SCRA 584 (1999); Reyes v. Sisters of Mercy Hospital, 341 SCRA 760, 770.

[233] RULES OF COURT, Rule 130, Sec. 26.

[234] Lashley v. Koerber, 156 P.2d 441.

[235] KING, *op. cit. supra* note 33, at 89.

[236] RULES OF COURT, Rule 130, Sec. 45.

[237] KING, *op. cit. supra* note 33, at 96.

[238] RULES OF COURT, Rule 130, Sec. 46. *See* 29 Am Jur 2d, EVIDENCE § 890

[239] KING, *op. cit. supra* note 33, at 102. First, the abundance of medical literature invites biased selective use. Second, statements in the medical literature may be much more extensive than manufacturer's recommendations, and thus more confusing and of debatable relevance. Finally, some statements in the literature may represent only one of a number of acceptable therapeutic alternatives.

People,[240] the Supreme Court cited "medical literature" which requires that the patient be weighed before *nubain* (an anesthesia) is administered and concluded that the physician who deviated from such standard is negligent. Likewise, in *Reyes v. Sisters of Mercy Hospital*,[241] the Supreme Court cited with approval the Court of Appeal's reliance on several medical books regarding the proper prescription.

e. *Violation of Statute, Regulation or Ordinance.* The fact that a defendant has violated a criminal or civil statute, regulation, or ordinance may support a finding of negligence even absent other proof of the applicable standard of care and its violation.[242] The statute, regulation or ordinance should be *applicable* to the case, i.e., (1) statute was designed to protect a class of persons of which plaintiff is a member; (2) the harm must have been a materialization of a risk the statute, etc. was designed to prevent. In the U.S., the authorities differ as to whether the presumption of negligence is conclusive or rebuttable. In the Philippines, in the case of *Teague v. Fernandez*[243] (non-medical malpractice) we have adopted the rule that such statutory violation constitutes negligence *per se*.

> If the very injury has happened which was intended to be prevented by the statute, it has been held that violation of the statute will be deemed to be the proximate cause of the injury...
>
> Violation of a statutory duty constitutes... negligence as a matter of law, or,... negligence *per se*... It is immaterial, where a statue has been violated, whether the act or omission constituting such violation would have been regarded as negligence in the absence of any statute on the subject or whether there was, as a matter of fact, any reason to anticipate that injury would result from such violation...

f. *Guidelines of Professional Organizations and Institutional Rules.* The modern trend in American jurisprudence is to treat them as "admissions by a party opponent," therefore, admissible as exception to hearsay. Such guidelines may represent collective expressions by the defendant's profession of the applicable standards of performance, and are thus relevant.[244] Hospital

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[240] 229 SCRA 386 (1994).
[241] 341 SCRA 760, 778 (2000).
[242] KING, *op. cit. supra* at 102
[243] 51 SCRA 181.
[244] KING, *op. cit. supra* at 108.

rules are also admissible as evidence of the standard of care,[245] although they are not conclusive.[246]

g. *Court Appointed Experts.*[247] The statute may even provide for judicial appointment of impartial experts, like Rule 706 of the U.S. Federal Rules of Evidence.

> *Rule 706. (a) Appointment.* – The court may on its own motion or on the motion of any party enter an order to show cause why expert witnesses should not be appointed, and may request the parties to submit nominations. The court may appoint any expert witnesses agreed upon by the parties, and may appoint expert witnesses of its own selection. An expert witness shall not be appointed by the court unless the witness consents to act.

This rule is a response to "the practice of shopping for experts, the venality of some experts, and the reluctance of many reputable experts to involve themselves in litigation."[248] However, even without such a provision in our Rules, a trial judge has an inherent power "to appoint an expert of his own choosing."[249] An express provision would simply remind and encourage judges to exercise this authority.

2. Causation

Like standard of care, causation is also usually proved by means of an expert witness (even where the standard of care falls under "common knowledge" situations[250]). A very important exception to this is the doctrine of *res ipsa loquitur*.[251] Actually, *res ipsa loquitur* may simply be treated as the use of *circumstantial evidence* alone to establish a finding of negligence and causation.[252] A clarification of

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[245] Pomani v. Underwood, 365 N.W.2d 286.

[246] Boland v. Garber, 257 N.W.2d 882.

[247] KING, *op. cit. supra* at 110.

[248] FEDERAL CIVIL JUDICIAL PROCEDURE AND RULES (West Pub., 1991) 349.

[249] Scott v. Spanjer Bros., Inc., 298 F.2d 928; Denville Tobacco Association v. Bryant-Buckner Associates, Inc., 333 F.2d 202.

[250] Fitzgerald v. Manning, 679 F.2d 341.

[251] Ramos v. Court of Appeals, 321 SCRA 584 (1999); Reyes v. Sisters of Mercy Hospital, 341 SCRA 760, 770, *et seq.*

[252] Technically speaking, *res ipsa loquitur* applies to the element of fault. However, the same circumstantial evidence that supports the application of *res ipsa loquitur* may also support a finding of at least some aspects of the causation inquiry. KING, *op. cit. supra* note 33, at 113.

this doctrine – its availability, scope, effects, elements – would be of great help to plaintiffs in establishing their case.

The elements of *res ipsa loquitur* have already been enunciated in several Philippine tort cases,[253] including cases on medical malpractice.[254] The classic formulation of Cooley is adopted by the Philippine cases, thus: "Where the thing which causes injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of an explanation by the defendant, that the accident arose from want of care."[255]

The *first* element is that the injury must have resulted from an occurrence which does not ordinarily occur in the absence of negligence, such that one could reasonably conclude that negligence by this defendant was more likely than not its cause.[256] Usually, it is limited to cases where the inference could be based entirely on the common knowledge of laymen. The most common examples are instances where a foreign object is left inside the body of the patient after surgery.[257] Also, a patient does not ordinarily become comatose after anesthesia is administered as to raise an inference of negligence under the doctrine of *res ipsa loquitur*.[258] Other examples of an injury which does not ordinarily occur include injuries sustained in a healthy part of the body which was not under treatment or removal of the wrong part of the body when another part is intended.[259]

Second, the injury must have been caused by an instrumentality or agency under the exclusive management or control of the defendant.[260] A problem would arise if more than one person exercised control over the patient. Traditionally (especially in non-malpractice cases), the plaintiff fails in his burden of proof against multiple defendants when he can only show that the negligence of one of them

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[253] Africa v. Caltex, 16 SCRA 448; Republic v. Luzon Stevedoring Co., 21 SCRA 279; F.F.Cruz v. Court of Appeals, 164 SCRA 731; Layugan v. IAC, 167 SCRA 363.

[254] Ramos v. Court of Appeals, 321 SCRA 584, 600 (1999); Batiquin v. Court of Appeals, 258 SCRA 334, 344-346 (1996).

[255] COOLEY ON TORTS, Vol. 3, at 369

[256] Africa v. Caltex, 16 SCRA 448; Republic v. Luzon Stevedoring Co., 21 SCRA 279; F.F.Cruz v. Court of Appeals, 164 SCRA 731; Layugan v. IAC, 167 SCRA 363.

[257] Batiquin v. Court of Appeals, 258 SCRA 334, 344-346 (1996).

[258] Ramos v. Court of Appeals, 380 SCRA 467 (2002).

[259] *Id.*, at 602, citing Thomsen v. Burgeson, 79 P.2d 136 and Griffin v. Norman, 192 NYS 322.

[260] Africa v. Caltex, 16 SCRA 448; Republic v. Luzon Stevedoring Co., 21 SCRA 279; F.F.Cruz v. Court of Appeals, 164 SCRA 731; Layugan v. IAC, 167 SCRA 363; Hale v. Venuto, 187 Cal. Rptr. 357; Wolfe v. Feldman, 286 N.Y.S. 118.

probably caused his injury, but is unable to specify which one. However, a more liberal stance is developing, such as in the *Ybarra v. Spangard* case,[261] where the Supreme Court of California held that "where a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries, may properly be called upon to meet the inference of negligence by giving an explanation of their conduct." Under this landmark doctrine, the burden of proving exoneration is shifted to each of the defendants.

Third, the injury must have occurred under circumstances indicating that it was not due to any voluntary act or negligence on the part of the plaintiff.[262]

In one case[263] not involving medical malpractice, the Supreme Court held that the *res ipsa loquitur* doctrine is a rule of evidence which can only be invoked when, under the circumstances, direct evidence is absent and not readily available. It cannot be availed of where plaintiff has knowledge and testifies or presents evidence as to the specific act of negligence or where there is direct evidence as to the precise cause of the accident and all the facts and circumstances attendant to the occurrence clearly appear.[264] This case seems to require that the plaintiff must somehow show that he exerted efforts to obtain expert testimony in vain, and seems to prevent him from pleading *res ipsa loquitur* alternatively with specific acts of negligence.

V. CONCLUSION

The medical profession reflexively, almost in a knee-jerk fashion, opposes any reforms in medical malpractice. Doctors oppose not only the crude House Bill 4955, but also the various Senate bills on patients' rights, which, they fear, will "spawn indiscriminate complaints and lawsuits against physicians."[265] Most of the concerns of doctors are legitimate and should be heard and addressed. They cannot be blamed for reacting critically and vehemently because some groups, including the media, have muddled the issues concerning medical malpractice and patients' rights.

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[261] 154 P.2d 687 (1944).

[262] KING, *op. cit. supra* note 33, at 123.

[263] Layugan v. IAC, 167 SCRA 363.

[264] *Id.*

[265] <http://www.pafp.net/pma_patient_rights.htm> However, "the Philippine Medical Association poses no objections to the various bills prohibiting the detention of patients, living or dead, in hospitals and medical clinics due to nonpayment of hospital and medical expenses."

However, the fears of the medical profession should not prevail over the pressing need to protect patients and the public at large from medical negligence and incompetence. There is a valid and genuine necessity to reform the law on medical malpractice. There are many issues and problems on malpractice which are not addressed by our present tort law, and it is still quite difficult to litigate malpractice suits successfully. But reform should not come in the form of drastic and draconian measures meant to terrorize the doctors, such as the criminalization of medical malpractice. A better and more sensible approach would be enacting a law that meets the needs of the public without unduly persecuting those giving health care. The solution is to craft a balanced and comprehensive legislation on medical malpractice that would lay down the rules and principles on medical malpractice as well as the rights of patients, thus eliminating uncertainties and confusion.

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