# THE TORT OF MEDICAL ERRORS: A CHANGE IN PERSPECTIVE*

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## ABSTRACT

The tort system has been used to determine negligence in medical malpractice cases. When a plaintiff is able to prove his claim through a preponderance of evidence, and a finding of fault is made, the tortfeasor is made liable and adjudged to pay damages, and sometimes results in the revocation of the license of the physician. Because of advances in medicine and the complex issues involved in both knowledge and practice, it may be proper to explore other means of dealing with professional error. There are some factors outside of human error which commonly considered that may influence the actions of physicians and, in turn, may affect outcomes, whether good or adverse. Injury is not always a result of fault or negligence but it may arise because of a series of events that converge to an adverse outcome. Alternative avenues for dispute resolution may better address these issues in order to come up with uniform standards for compensation, and the achievement of the goal towards prevention of injury in the future.


## I. INTRODUCTION

"The most formidable weapon against errors of every kind is [r]eason."[1] It rings true today, especially in the field of law and medicine. A sound and reasonable argument can help win a lawyer's case while presumptions can potentially destroy it. In medicine, presumptions are also fatal if not coupled with a thorough study of the root cause of a disease. These two areas of study may seem so far removed from each other but they converge so intimately when medical errors occur.

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* *Cite as* Stephanie Anne Oracion, *The Tort of Medical Errors: A Change in Perspective*, 91 PHIL. L.J. 441, (page cited) (2018).

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[1] THOMAS PAINE, THE AGE OF REASON vii (G.P. Putnam's Sons ed. 1896).

Black's Law Dictionary defines tort liability as "[t]he obligation, legally, of one party to the victim resulting from a civil wrong or injury."[2] James Reason defines error as "a planned sequence of mental or physical activities fails to achieve its intended outcome and these failures cannot be attributed to the intervention of some chance or agency," and as "deficiencies in the in the judgmental and/or inferential processes involved in the selection of an objective or in the specification of the means to achieve it, irrespective of whether or not the actions directed by this decision-scheme run according to plan."[3] It may also include deviations from the process of care, which may or may not cause harm to the patient.[4] Others say it is "an unintended act (either of omission or commission) or one that does not achieve its intended outcome."[5] When closely examined, however, not all adverse patient outcomes are the result of error.[6] In most instances, there are factors beyond human control that lead to unintended results. For example, when a patient falls and suffers an injury while under the care of a doctor, it may, at the outset, be construed as the doctor's fault. However, it is entirely possible that the patient was a large person who was restless, agitated, and beyond what the doctor could reasonably manage at that very moment. Therefore, the outcome is accidental and not wholly due to negligence.

An examination of another definition opens up a broader perspective on this issue. A Canadian researcher described it as "an act of omission or commission in planning or execution that contributes or could contribute to an unintended result."[7] In contrast with the first definition of medical error, it does not focus on acts, omissions, planning, or execution but instead considers "faulty processes," whatever the outcome may be. It takes away the spotlight from human fault and evaluates the process itself to come up with a clearer and more detailed picture of the incident.

In other countries, specific laws are in place to regulate work hours, including the practice of the medical profession. Examples of these are the European Working Time Directive ("EWTD"), which requires all member states of the European Union to comply with restrictions on working hours,

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[2] BLACK'S LAW DICTIONARY 126 (9th ed. 2009).

[3] JAMES REASON, HUMAN ERROR 9 (1990).

[4] James Reason, *Understanding adverse events: the human factor*, 4 QUALITY IN HEALTH CARE 80 (1995), *available at* https://qualitysafety.bmj.com/content/qhc/4/2/80.full.pdf.

[5] Leape Lucian, *Error in Medicine*. 272 JAMA 1851, 1851-1857 (1994), *available at* http://www.uphs.upenn.edu/gme/pdfs/Leape_Error%20in%20Medicine_JAMA.pdf.

[6] Ethan Grober & John Bohnen, *Defining Medical Error*, 48 CANADIAN J. OF SURGERY 39, 40 (2005).

[7] *Id.* at 42.

and the Accreditation Council for Graduate Medical Education ("ACGME") in the United States. In the Philippines, there is Republic Act No. 2382 or the "Medical Act of 1959". However, this law is antiquated and does not give the exact conditions or requisites for a finding of medical negligence. It only provides for "reprimand, suspension or revocation of registration" on the ground of "[g]ross negligence, ignorance or incompetence in the practice of his or her profession resulting in an injury to or death of the patient."[8] There are no conditions as to how these findings are met, so the provisions of the Civil Code are applied. In addition, the standards are culled from the various pronouncements of the Supreme Court in cases brought before it.[9] For a profession as complex and highly specialized as medicine, a specific set of rules would better address any failure in the system especially when injury occurs to patients. It would also develop more consciousness towards prevention of errors.

This Note analyzes the applicability of the tort system in dealing with medical malpractice by looking at the contributory factors involved in coming up with a decision from both the physician's and patient's perspectives. The objective is to examine a few possible causes and the different layers of the system as it relates to medical tort, and to identify possible alternative solutions towards a better legal response and structure. Finally, this Note explores the possibility of implementing a novel approach to medical malpractice through non-adversarial means and specialized bodies called health courts.

This Note starts with a review of the materials currently dealing with medical malpractice, such as jurisprudence and statistical reports on its incidence both abroad and in the Philippines. It includes an analysis of the usual legal responses to medical errors and the factors contributing to adverse outcomes. European and American rules and regulations are examined to determine their feasibility and applicability in the Philippines. Finally, this Note concludes with recommendations for alternatives to the tort system, and the manner by which cases of medical negligence are decided.

## II. LITERATURE REVIEW

### A. Medical Malpractice

[8] Rep. Act No. 2382 (1959), § 24 (5).

[9] Darwin P. Angeles, *A Framework of Philippine Medical Malpractice Law*, 85 PHIL. L.J. 895, 903 (2011).

Every person who enters a profession undertakes to practice it with care and diligence. When a wrong is committed, there should be accountability. This has long been recognized, particularly in medicine, since the time of the Romans. At present, it is known as medical malpractice. Medical malpractice is a specific subset of tort law that deals with professional negligence. It is defined as "any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice in the medical community and causes an injury to the patient."[10] The liability could be civil under tort law or criminal under the Revised Penal Code.

Medical malpractice cases in the Philippines are decided based on the standards set by the Civil Code and jurisprudence. The general rule is that in medical negligence cases, the complainant has the burden of establishing breach of duty on the part of the doctors or surgeons.[11] In *Cayao-Lasam v. Ramolete*,[12] the Supreme Court declared that

> [m]edical malpractice, in our jurisdiction, is often brought as a civil action for damages under Article 2176 of the Civil Code. The defenses in an action for damages, provided for under Article 2179 of the Civil Code are:
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> > 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.[13]

Under jurisprudence, the standard consists of the existence of a duty on the part of the physician. Any alleged deviations from such duty must be proven by a preponderance of evidence in a case for damages, or proof beyond reasonable doubt in criminal cases to make the practitioner liable. However, most, if not all cases, are adversarial and heard before trial courts. There is no neutral forum where both parties might be better heard. In addition, an ordinary civil case takes several years before the Supreme Court is able to render a final decision but in medical malpractice cases, such a

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[10] Bal B. Sonny, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPEDICS & RELATED RES. 339, 339–347 (2008).

[11] Cereno v. Ct. of Appeals [hereinafter "Cereno"], G.R. No. 167366, 682 SCRA 18, 33, Sept. 26, 2012.

[12] Hereinafter "Cayao-Lasam", G.R. No. 159132, 574 SCRA 439, Dec. 18, 2008.

[13] *Id.* at 458.

time-consuming and costly process tends to water down the parties' interest in pursuing the case. Also, the amount of damages sought at the onset may not be as valuable 10 or 20 years later when the case is finally disposed of by the Supreme Court.

### B. The Libby Zion Case

In the United States, the impetus to the creation of medical malpractice policies started with the case of 18-year old Libby Zion.[14] Libby was rushed and admitted to a New York City hospital following the development of a fever after a recent tooth extraction. When she was interviewed by the junior resident, she revealed her history of psychiatric treatment and use of both therapeutic and recreational drugs. In fact, she had just taken an antidepressant called "Nardil" before she was brought to the hospital. She was restless and agitated while being examined, and she was diagnosed to have Viral Syndrome. A sedative called "Demerol" was then given via intramuscular injection to calm her down.

Unfortunately, in 1984, there was very little information about drug-to-drug interaction between Nardil and Demerol. After receiving Demerol, Libby's temperature spiked to 107 degrees Fahrenheit, which resulted in cardiac arrest and, eventually, her death. The doctors who treated Libby were sued by her father for their negligence. Mr. Zion's main contention was that the hospital was negligent in assigning too many patients but later, the courts found that it was not the proximate cause of Libby's death. Regardless, the doctors were made to pay USD 350,000.00 as settlement. The hospital was likewise fined USD 13 million for failing to meet the standard of care required. [15] An investigating group, called the Bell Commission and which was formed by the New York State Commissioner of Health, came up with 19 recommendations for the regulation of the profession, [16] which include regulation of duty hours and increased supervision. When the incident occurred, very few practitioners knew about the adverse effects of the drugs that were administered to Libby. Nevertheless, the doctors were labeled as negligent and incompetent and were made to pay a huge compensation.

### C. Incidence of Medical Malpractice in the Philippines

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[14] Nachiket Patel, *Learning Lessons,* 64 J. AM. C. CARDIOLOGY 2802, 2802-2804 (2014).

[15] Milton Kramer, *Sleep loss in resident physicians: the cause of medical errors?* 1 FRONTIERS IN NEUROLOGY 1, 1-10 (2010), *available at* https://www.frontiersin.org/articles/10.3389/ fneur.2010.00128/full.

[16] *Id.* at 2.

In 2002, the Professional Regulation Commission ("PRC") recorded that there were only 600 doctors involved in medical malpractice cases who were seeing an average of 10 patients a day, five times a week.[17] At that time, there were 176 medical malpractice claims out of the 585 cases docketed with the Board of Medicine. Unfortunately, very little data about its incidence, and cost incurred by both the doctors and the plaintiffs in legal proceedings, is available to the public largely because most incidents are left unreported.

Death from medical errors is not officially listed as a cause of death in world statistics, but a Johns Hopkins University study concluded in 2016 found that it was the third leading cause of death in the US.[18] The study further suggests that "most medical errors are not due to inherently bad doctors, rather, most errors represent systemic problems, including poorly coordinated care, fragmented insurance networks, the absence or underuse of safety nets, and other protocols, in addition to unwarranted variation in physician practice patterns that lack accountability."[19] In Europe, particularly the United Kingdom, Spain, France and Denmark, health care-related adverse events happen in about 8-12% of hospitalizations.[20]

### D. Laws and Jurisprudence on Medical Malpractice and the Doctrine of *Res Ipsa Loquitur*

While the Libby Zion Case was the precursor of medical malpractice legislation and regulation, the Philippine case of *Garcia-Rueda v. Pascasio*[21] was pivotal in laying down the elements of medical malpractice, namely: duty, breach, injury, and proximate causation. In this case, petitioner's husband died after undergoing an operation to remove a stone that was blocking his urinary tract. The cause of death was designated as "unknown." While the suit was criminal in nature, the Supreme Court declared for the first time that

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[17] Rey Gamboa, *The bitter pill of medical malpractice*, PHILSTAR, Nov. 8, 2002, *available at* https://www.philstar.com/business/2002/11/08/183114/bitter-pill-medical-malpractice.

[18] Vanessa McMains, *Johns Hopkins study suggests medical errors are third-leading cause of death in U.S.*, THE HUB WEBSITE, *at* https://hub.jhu.edu/2016/05/03/medical-errors-third-leading-cause-of-death/ (last visited July 9, 2018).

[19] *Id.*

[20] World Health Organization Regional Office for Europe, *Data and Statistics*, WHO WEBSITE, *at* http://www.euro.who.int/en/health-topics/Health-systems/patient-safety/data-and-statistics (last visited July 10, 2018).

[21] Hereinafter "Garcia-Rueda", G.R. No. 118141, 278 SCRA 769, Sept. 5, 1997.

> [i]n order to successfully pursue such a claim, a patient must prove that a health care provider, in most cases a physician, either failed to do something which a reasonably prudent health care provider would have done, or that he or she did something that a reasonably prudent provider would not have done; and that that failure or action caused injury to the patient.[22]

The Supreme Court concluded that there must be a causal connection between the victim's death and the negligent act. In *Cantre v. Spouses Go*,[23] the Supreme Court ruled that the Hippocratic Oath mandates physicians to consider the well-being of their patients. If a doctor fails to live up to this precept, he is accountable for his acts. In *Garcia-Rueda*, it was also determined that the charge of *res ipsa loquitur* was readily available to a plaintiff to hold the practitioner liable for any adverse outcome. However, the doctrine of *res ipsa loquitur* is not intended to, and does not dispense with, the requirement of proof of culpable negligence on the party charged.[24] The requirement is that he or she must be able to present competent proof, such as expert testimony by other doctors or documentary evidence such as nurses' notes, to support the charge of negligence.

As explained in the case of *Layugan v. Intermediate Appellate Court*,[25] *res ipsa loquitur* is

> a rule of evidence whereby negligence of the alleged wrongdoer may be inferred from the mere fact that the accident happened provided the character of the accident and circumstances attending it leads to a reasonable belief that in the absence of negligence it would not have occurred and that thing which caused injury is shown to have been under the management and control of the alleged wrongdoer.[26]

In the case of *Ramos v. Court of Appeals*,[27] the doctrine of *res ipsa loquitur* was applied thus:

> Where common knowledge and experience teach that a resulting injury would not have occurred to the patient if due care had been exercised, an inference of negligence may be drawn giving rise to

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[22] *Id.* at 778.

[23] Hereinafter "Cantre", G.R. No. 160889, 522 SCRA 547, Apr. 27, 2007.

[24] Batiquin v. Ct. of Appeals [hereinafter "Batiquin"], G.R. No. 118231, 258 SCRA 334, 345, July 5, 1996.

[25] G.R. No. 73998, 167 SCRA 363, Nov. 14, 1998.

[26] *Id.* at 376, *citing* Black's Law Dictionary 1173 (5th Ed. 1981).

[27] G.R. No. 124354, 321 SCRA 584, Dec. 29, 1999.

> an application of the doctrine of *res ipsa loquitur* without medical evidence, which is ordinarily required to show not only what occurred but how and why it occurred. When the doctrine is appropriate, all that the patient must do is prove a nexus between the particular act or omission complained of and the injury sustained while under the custody and management of the defendant without need to produce expert medical testimony to establish the standard of care. Resort to *res ipsa loquitur* is allowed because there is no other way, under usual and ordinary conditions, by which the patient can obtain redress for injury suffered by him.[28]

This doctrine was also applied in *Batiquin v. Court of Appeals*,[29] where, in ruling for the patient, the Supreme Court declared that the piece of gauze found in the patient's abdomen, which caused the ensuing infection, was enough to overcome the defense of the physician-in-charge. The Court stated that:

> The doctrine is not a rule of substantive law, but merely a mode of proof or a mere procedural convenience. The rule, when applicable to the facts and circumstances of a particular case, is not intended to and does not dispense with the requirement of proof of culpable negligence on the party charged. It merely determines and regulates what shall be prima facie evidence thereof and *facilitates the burden of plaintiff of proving a breach of the duty of due care*. The doctrine can be *invoked when and only when, under the circumstances involved, direct evidence is absent and not readily available*.[30]

Again, the doctrine of *res ipsa loquitur* is not the gold standard. The plaintiff must still show by preponderance of evidence in civil cases, or proof beyond reasonable doubt in criminal cases, that the negligent act was the proximate cause of the injury.

Another important factor to be considered in medical malpractice cases is the length of time by which cases are decided. While the Supreme Court has ruled in favor of the plaintiff in a number of cases, litigation in the lower courts alone may last as long as 15 years. A case in point is *Nogales v. Capitol Medical Center*,[31] where the patient experienced profuse vaginal bleeding after giving birth to her child in 1976. Despite resuscitative measures by the doctors, the patient died. The trial in the lower courts lasted

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[28] *Id.* at 601-602.

[29] *Batiquin*, 258 SCRA 334.

[30] *Id.* at 345. (Emphasis supplied.)

[31] G.R. No. 142625, 511 SCRA 204, Dec. 19, 2006.

11 years and ended in 1993. The case was appealed and eventually decided by the Supreme Court in favor of the claimants in 2006. In the more recent case of *Casumpang v. Cortejo*,[32] involving the death of an 11 year-old boy in 1988 due to Stage IV Dengue Hemorrhagic Fever, the trial in the lower courts lasted until 1997 and was eventually decided in favor of the claimant in 2015, with the Court awarding PHP 45,000.00 as actual damages and PHP 500,000.00 as moral damages. These cases are examples of the time-consuming process that the parties have to go through to settle their claims. By the time the damages are awarded, the patient, if injured, could be dead, or the money that could have been more useful at the commencement of the case becomes less valuable at the end.

In terms of legislation, there is yet no updated law in the Philippines that regulates the practice of medicine and any related adverse events. In 2004, a Senate Bill was introduced by then-Senator Sergio Osmeña III,[33] the explanatory note of which states that:

> This bill aims to address the alarming incidents of medical malpractice and gross negligence, resulting in complications, aggravated injuries, and even death. In proving penalties for gross negligence, it is hoped that all fields of the medical profession will be protected against incompetent individuals.
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> To compensate the general public for injuries or death resulting from medical and dental malpractices, this bill also seeks to institutionalize a system of claims and benefits. It requires all medical and dental practitioners to obtain malpractice insurance in an amount not less than fifty thousand pesos (P50,000) to answer any claims for damages arising from act or omission perpetuated by the insured resulting into injury, or loss of life or limb of any person.[34]

The bill consists of 12 sections which sets out the procedure for complaints, penalties, and damages rendered against a practitioner found to be guilty of malpractice. Section 4 states:

> Any medical practitioner who performs any act constituting medical malpractice or the illegal practice of surgery

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[32] G.R. No. 171127, 752 SCRA 379, Mar. 11, 2015.
[33] S. No. 1720, 13th Cong., 2nd Sess. (2005). Anti-Medical Malpractice Act of 2004.
[34] *Id.*

> shall be punishable by imprisonment or fine or both and, *in all instances*, the cancellation of the license to practice medicine.[35]

The most significant portion of Section 4 is the cancellation of the license to practice the medical profession in all instances, regardless of the circumstances surrounding the case. On the part of the plaintiff, this could signify vindication, but on the part of the doctor, it could spell ruination. On the other hand, if the plaintiff lacks the resources to pursue his claim, a truly negligent doctor may end up doing more harm than good.

Another important provision of the bill is Section 10, *viz*:

> Upon approval of this Act, all physicians and dentists shall be required to obtain *medical and dental malpractice insurance of no less than fifty thousand pesos (P50,000.00)* from any reputable and duly licensed insurance company to answer for any claims for damages arising from an act or omission perpetrated by the insured resulting into injury, loss of life or limb to any person. Failure on the part of the Physician or Dentist to comply with the provisions of this Act cause the suspension of his professional license and shall remain effective until he/she complied therewith.[36]

At present, doctors are not required to procure medical insurance as a condition to practice medicine. This provision is a potentially significant step towards achieving the bill's aim to "institutionalize a system of claims and benefits.".

## III. THE LEGAL RESPONSE TO MEDICAL ERRORS: THE TORT SYSTEM

### A. The Duty of Care

The relationship between a doctor and a patient requires a standard of care imposed on all practitioners within the field. An American case states that

> [t]he duty of a physician or surgeon to bring skill and care to the amelioration of the condition of his patient does not arise from contract, but has its foundation in public considerations which are inseparable from the nature and exercise of his calling; it is

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[35] § 4. (Emphasis supplied.)

[36] § 10.

> predicated by the law on the relation which exists between physician and patient.[37]

In the Philippines, the Supreme Court restated this duty as the "degree of care, skill and diligence which physicians in the same general neighborhood and in the same general line of practice ordinarily possess and exercise in like cases."[38] The Court further stated that

> [w]hen a patient engages the services of a physician, a physician-patient relationship is generated. And in accepting a case, the physician, for all intents and purposes, represents that he has the needed training and skill possessed by physicians and surgeons practicing in the same field; and that he will employ such training, care, and skill in the treatment of the patient. [...] Stated otherwise, the physician has the obligation to use at least the same level of care that any other reasonably competent physician would use to treat the condition under similar circumstances.[39]

The duty of care among medical professionals requires that within a certain group of doctors specializing in a certain field, ordinary diligence is required to be exercised. For example, ordinary diligence as a community standard is different in surgical specialties as against pathology, pediatrics, or oncology. Thus, when a case for medical negligence is brought before the courts, it is very important to understand the highly technical and mostly complex terms and procedures that should aid the courts towards a finding of either negligence on the part of the doctor or contributory negligence by the patient. With due fairness to all parties, the application of the standard should be uniform for all in the same class, and liability should be gauged according to the circumstances of each act, whether it was negligent or not.

## B. Negligence

The principles that deal with negligence in general have been applied in medical malpractice suits in the Philippines. There may be two sources of obligation in a case for medical malpractice. In *Cereno*, the Supreme Court stated that:

> In medical negligence cases, it is settled that the complainant has the burden of establishing breach of duty on the part of the doctors or surgeons. It must be proven that such

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[37] Norton v. Hamilton, 92 Ga. App. 727, 731 (1955).
[38] Lucas v. Tuaño, G.R. No. 178763, 586 SCRA 173, 200, Apr. 21, 2009.
[39] *Id.*

> breach of duty has a causal connection to the resulting death of the patient. A verdict in malpractice action cannot be based on speculation or conjecture. Causation must be proven within a reasonable medical probability based upon competent expert testimony.[40]

Negligence may be proven by an expert witness belonging in the same "general neighborhood" and in the same general line of practice as the defendant physician or surgeon.[41] The current standard is a reasonably competent doctor against one who has acted negligently based on the act or omission. Negligence is measured according to the standard of care observed by other members of the profession in good standing, and under similar circumstances or specialty.[42] As additional evidence, the Court has used clinical literature as the basis of expert testimony, such as the pharmaceutical package insert instruction and warnings, learned treatises, research findings, and clinical practice guidelines. One weakness of this standard is that while the expert witness may be as competent as the defendant doctor, the witness may not be a specialist in the same field. For example, while a general practitioner is familiar with the administration of chemotherapeutic drugs, an oncologist would be more credible as an expert witness. Also, a doctor of a private, well-equipped hospital will be able to testify on ideal bedside practices to avoid injury to patients, as against an overworked public hospital doctor affected by other factors beyond his control that have contributed to the act or omission. The Supreme Court has acknowledged that:

> doctors are protected by a special rule of law. They are not guarantors of care. They are not insurers against mishaps or unusual consequences specially so if the patient herself did not exercise the proper diligence required to avoid the injury.[43]

No practitioner can guarantee positive outcomes. Lord Alfred Thompson Denning, an English lawyer and judge, stated that "medical science has conferred grate benefits on mankind, but these benefits are attended by considerable risks."[44] Our own Court has conceded that it was "face[d] with a unique restraint in adjudicating medical negligence cases

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[40] 682 SCRA 18, 33.

[41] *Id.* at 26.

[42] TIMOTEO T. AQUINO, TORTS AND DAMAGES 179-190 (2013).

[43] *Cayao-Lasam*, 574 SCRA 439, 461.

[44] Roe v. Minister of Health, 2 Q.B. 66 (1954).

because physicians are not guarantors of case and, they never set out to intentionally cause injury to their patients."[45]

Given the complex procedures and complicated terms involved in these cases, it may be more appropriate to explore other methods to truly encapsulate all the aspects of a medical malpractice case. It would involve a more specialized and non-adversarial forum to examine in greater detail the facts and circumstances of each case. This could result in a more informed decision and a faster resolution of what would be beneficial to both the claimant and the doctor involved.

### C. Adverse Event vs. Medical Error

A look past the tort system reveals many "internal" causes of medical errors. There is in fact a difference between medical negligence, and what is properly termed as "adverse events". When a patient dies or suffers grave injury because of an extreme allergic reaction to a medicine, this is characterized as an adverse event. On the other hand, negligence precedes a standard level of care that was not met. The adverse event only becomes a form of negligence if the physician failed to take all the necessary and reasonable precautions under the circumstances. But not all adverse events are the result of negligence. A Harvard Public Health study showed that only 27% of adverse events were due to negligence.[46] Like all professions, medicine is not an exact science and can never be free from complications. Even under the most capable hands, adverse outcomes may still occur as an inherent risk in the practice of medicine.[47] As previously mentioned, even the Supreme Court acknowledges this fact. The distinction between an adverse event and negligence is important with regard to the imputation of the proper degree of liability because punishing adverse events per se would have a "chilling effect" on the conduct of more complex procedures.[48]

### D. Existing Laws in Other Countries

Other countries have passed laws and policies regulating the practice of medicine. In the United States, a common feature of malpractice laws is

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[45] *Cantre*, 522 SCRA 547, 555.

[46] Troyen Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 NEW ENGLAND J. MED. 370 (1991).

[47] David Sohn, *Negligence, genuine error, and litigation*, 6 INT'L J. GEN. MED. 49 (2013).

[48] *Id.*

the "Damage Awards Limit or Cap".[49] This was introduced as a response to the increasing cost of medical insurance. Another peculiar feature of US law is the "I'm sorry" clause. In this agreement, medical staff are given the opportunity to express their condolences or apologies to the families of the victims or the victim themselves in the belief that such gestures will contribute in the reduction of medical malpractice litigation.[50] Many states have also passed laws requiring pre-trial alternative dispute resolution, and a screening panel to review the complaint before it proceeds to court.[51] These laws also require an affidavit or certificate of merit executed by the health professional stating that has reviewed the notice (or complaint) and all medical records supplied to him or her by the plaintiff's attorney concerning the allegations. It may also contain a statement on the applicable standard of care, that in the health professional's opinion, the standard of care was breached, and that breach was the proximate cause of the injury alleged.[52] Lastly, it contains specific criteria for an expert witness specializing in the medical field and, finally, a medical or peer review panel to aid in the evaluation of the facts and evidence.[53]

There are differing approaches to medical malpractice in the European Union but countries like Italy use the common law system in dealing with tort liability. In China, there is a so-called "bifurcation" on medical negligence laws, which involves an administrative regime favorable to the medical personnel, and a judicial regime which leans towards the plaintiff's side. An attempt has been made to merge these regimes into one Tort Liability Law, but it has been unsuccessful, and recent cases have been decided based on existing provisions of the old law.[54]

In Thailand, the prevalence of cosmetic surgeries and adverse outcomes has paved the way for a bill under consideration in the Thai legislature. It attempts to balance the desire of the medical profession to protect overworked doctors from malpractice suits, and the desire of victims' rights groups to protect patients who claim to be the victims of negligent malpractice. It is called a "no-fault" bill, or formally, the Medical Malpractice Victim's Fund Bill, which would provide a non-tort avenue for

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[49] US National Conference of State Legislatures, *Medical Liability/Malpractice Laws*, NCSL WEBSITE, *at* http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx (last visited July 9, 2018).

[50] *Id.*

[51] *Id.*

[52] Revised Judicature Act of the State of Michigan (1961), §2912(d).

[53] US National Conference of State Legislatures, *supra* note 49.

[54] Chao Xi & Lixin Yang, *Medical liability laws in China: The tale of two regimes*, 19 TORT L. REV. 65 (2011), *available at* http://ssrn.com/abstract=2087577.

potential malpractice plaintiffs to be compensated without holding the doctor in question criminally or civilly responsible.[55] Under this bill, public and private hospitals who want to be covered contribute to a pool which will be used as compensation for malpractice claims similar to malpractice insurance. Consequently, the victims are barred from pursuing civil or criminal cases once compensation is accepted.[56]

### E. Problems on the Implementation and Enforcement of Policies

While the Philippines lacks the much needed law, medical institutions are free to implement their own policies for their own employees. In reality, doctors work for very long hours with only short breaks in between a rigorous daily cycle leading to possible compromises in the quality of their work along the way.

The Department of Health (DOH) admitted that the shortage of beds remains a challenge in government hospitals, as 800 people struggle for one hospital bed, a 1:800 ratio in Metro Manila alone.[57] As a result, patients may suffer the most injury because of poor conditions both for the patients and the employees. However, it is more than likely that not all incidents of negligence are reported. Unfair and unequal access to health care leaves the poor behind leading to untreated diseases and high maternal and newborn deaths.[58] There could also be many unreported cases of negligence because the victims are either too poor to afford long, drawn-out proceedings and others might be intimidated by the idea of going to court.

### F. Negative Effects of a Finding of Liability

Under Senate Bill No. 1720, the finding of liability will entail a fine, imprisonment, and the revocation of the physician's medical license, but the law is silent on how the liability is assessed. Furthermore, the consequences of a finding of negligence goes beyond the loss of privilege to practice the profession. It carries a stigma that one has failed or is incompetent when it is

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[55] Jason Armbrecht, *Medical Malpractice in Thailand: Patient Rights in the Medical Tourism Industry*, THAI LAW FORUM WEBSITE, *at* http://www.thailawforum.com/Medical-Malpractice-Thailand.html (last visited July 9, 2018).

[56] *Id.*

[57] Jovee Marie dela Cruz, *DOH admits lack of beds in Metro Manila hospitals*, BUSINESSMIRROR, Aug. 15, 2017, *available at* https://businessmirror.com.ph/doh-admits-lack-of-beds-in-metro-manila-hospitals/.

[58] *Why the Philippine Healthcare System Model is Flawed*, MEDICAL OBSERVER WEBSITE, *at* https://medicalobserverph.com/specialreport-why-the-philippine-healthcare-system-model-is-flawed/ (last visited Aug 4, 2018).

not always the case because there is a series of events involved that leads to a positive or negative outcome.

Medicine is different from other fields where the risk is focused on money or profit. Health care providers are motivated by their oath to "do no harm", and to treat the patient to the best of their ability.[59] According to a report, physicians as a group are already "ethically motivated to avoid negligent behavior, and the threat of litigation does not add to this motivation."[60] Litigation has a negative effect on a doctor's performance. It creates fear and anxiety, and fractures the doctor–patient relationship, causing physicians to fear potential suits. It also gives rise to the tendency to practice defensive behaviors, so doctors avoid offering high-risk but effective services, such as obstetrics or neurosurgery.[61]

## IV. A CHANGE IN PERSPECTIVE

The plaintiff, like in all cases, bears the burden of proving his case. Unfortunately, a plaintiff may lose his case for reasons beyond his control. In the case of *Cereno*, the doctors were sued for the death of a stabbing victim. In this case, the operation of the patient was deferred after admission despite the fact that he had several puncture wounds and almost three liters of blood in his lungs. When the patient was finally operated on, he bled out on the table and eventually died because blood was not transfused to him on time. The trial court found the doctors negligent for not immediately operating on the patient when he came to the emergency room. The doctors, in their Motion for Reconsideration before the Court of Appeals, reasoned that the patient's vital signs were stable upon admission so there was no need to transfuse any blood. The Supreme Court ultimately held that the doctors were not liable because the delay in the transfusion was due to the blood having to be cross-matched with the patient's blood type, a process that took at least 45 minutes. No damages were awarded to the plaintiff.[62]

In other cases, the plaintiff may not be able to present sufficient evidence to support the patient's claim. It may also be that the expert

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[59] *See* G. Kevin Donovan, *Doctors, Documentation, and the Professional Obligation: Has Everything Changed?*, 82 LINACRE Q. 197, 198 (2015)

[60] Sohn, *supra* note 47, at 51.

[61] *Id.*

[62] *Cereno,* 682 SCRA 18, 25.

witness is incompetent to testify on the issue. In the case of *Borromeo v. Family Care Hospital, Inc.*,[63] the Supreme Court declared that:

> Whoever alleges a fact has the burden of proving it. This is a basic legal principle that equally applies to civil and criminal cases. In a medical malpractice case, the plaintiff has the duty of proving its elements, namely: (1) a duty of the defendant to his patient; (2) the defendant's breach of this duty; (3) injury to the patient; and (4) proximate causation between the breach and the injury suffered. In civil cases, the plaintiff must prove these elements by a preponderance of evidence.
>
> Because medical malpractice cases are often highly technical, expert testimony is usually essential to establish: (1) the standard of care that the defendant was bound to observe under the circumstances; (2) that the defendant's conduct fell below the acceptable standard; and (3) that the defendant's failure to observe the industry standard caused injury to his patient.
>
> The expert witness must be a similarly trained and experienced physician. Thus, a pulmonologist is not qualified to testify as to the standard of care required of an anesthesiologist and an autopsy expert is not qualified to testify as a specialist in infectious diseases.[64]

An act or omission causing injury must be accounted for using all the available facts and circumstances of each case, and not simply be oriented towards the finding of negligence or criminal liability. In reality, there are many factors behind every act, but the law emphasizes payment for damages or penalties. It is important to consider the "hows" and "whys" not only of the act and the result, but also the preceding events that led to the injurious act itself. As for patients and their families, they run the risk of having to end up with nothing even after years and years of back and forth in the courts.

### A. Work Hours and Lack of Sleep: Is there a Connection with Medical Errors?

Many studies have concluded that sleep plays a major role in the normal day-to-day functioning of humans. It is recommended that an adult should get at least six hours of sleep in 24 hours, as anything less than six

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[63] G.R. No. 191018, 781 SCRA 527, Jan. 25, 2016.

[64] *Id.* at 539-540.

hours will affect one's alertness.[65] History has recorded numerous events in which sleep deprivation played a regrettable part. Investigations of the grounding of the Exxon Valdez oil tanker, as well as the explosion of the space shuttle Challenger concluded that sleep deprivation was an important contributor to these accidents. The persons in charge of the operations and who were required to make critical decisions were operating under extreme sleep deprivation. The Challenger disaster put the multi-billion-dollar shuttle program in peril, and the Exxon Valdez oil spill resulted in serious ecological, environmental, and economic damage. The United States enacted the US Code of Federal Regulations as a response to this problem.[66]

It was found that missing only one night of sleep results in a cognitive decline similar to having a blood alcohol level of 0.1% which is significantly higher than the legally accepted standard of 0.05%. An individual who chronically gets only two to three hours of sleep each night suffers from poorer motor skills, altered mood, and cognitive impairment.[67] Research also shows that sleep deprivation among physicians leads to emotional disturbances such as depression, cynicism, lack of empathy for patients, and suicide.[68] In practice, some known effects of sleep deprivation include impairment of electrocardiogram (ECG) interpretation, poorer quality intubations, and increased performance time and error rates on procedures, especially in intensive care units.[69]

One contentious issue since the Libby Zion case is how fatigue contributes to medical errors because of the number of work hours of physicians. In the Philippines, the standard number of regular duty hours is 36 hours every other day for a total of approximately 140 hours per week. Libby Zion's death led to the enactment of state legislation in 1989 restricting work hours from 120 hours per week to 80 hours, with no shift longer than 24 hours.[70] A study conducted in 2004 measured the percentage of errors committed during a regulated intervention period. During this time, every shift was limited to a maximum of 24 hours per day, and the

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[65] Mary Carskadon & William Dement, *Nocturnal Determinants of Daytime Sleepiness*, 5 SLEEP S73-S81 (Suppl. 2, 1982), *available at* https://academic.oup.com/sleep/article/5/suppl_2/ S73/2753306.

[66] Harvard Medical School, *Sleep, Performance, and Public Safety*, HARVARD MEDICAL SCHOOL WEBSITE, *at* http://healthysleep.med.harvard.edu/healthy/matters/consequences/sleep-performance-and-public-safety (last visited July 9, 2018).

[67] *See* Richard Eddy, *Sleep deprivation among physicians*, 47 BC MED. J. 176-180 (2005).

[68] *See* Judith Samkoff & C. H. Jacques, *A Review of Studies Concerning Effects of Sleep Deprivation and Fatigue on Residents' Performance*. 66 ACAD. MED. 687-693 (1991).

[69] *Id.* at 692.

[70] Eddy, *supra* note 67, at 177.

average duration of sleep was increased to 1 hour while weekly duty hours were lessened to 20 hours per week. It was found that medical errors were 22% more likely to be committed outside the intervention period.[71] The study concluded that an increase in sleep from the elimination of extended work shifts and reduction of work hours would lead to a decrease in medical errors.[72] However, another study conducted in the same year shows quite the opposite results in relation to work hours.[73] Fatigue is always thought of as the obvious culprit, but it was discovered that it could be offset by other factors such as a good staff support and stable leadership from superiors. In the end, long duty hours had little effect on performance; instead, the work environment and relationships with co-workers were found to have greater impact. A subsequent study in 2010 confirmed the fact that it was inconclusive whether or not a reduction in work hours would have a positive impact on patient safety.[74]

### B. An Economic View: Unilateral vs. Bilateral Accidents

We now consider an economic view of tort law which distinguishes between unilateral and bilateral accidents. In the unilateral view, there is only one party, the doctor, who plays an active role, and is the only one who can take precautionary measures to prevent accidents. The patient is a mere recipient of potential harm.[75] In bilateral accidents, both the physician and patient can take precautions to reduce the risk of harm.[76]

Medical injuries are generally viewed in the unilateral sense and weighed against the failure to meet the standard of care. According to this model, when the doctor raises and goes above the standard of care, his cost of care increases. Inversely, accident losses decrease. It is a rather simple formula, but it is difficult to determine the ideal level of care with reasonable certainty, even for specialists in the field. The task is then left up to the courts to appraise the acts of physicians in terms of customary standards of practice within the medical profession.[77] With the court's discretion, the

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[71] *See* Christopher Landrigan et al., *Effect of Reducing Interns' Work Hours on Serious Medical Errors in Intensive Care Units*, 18 NEW ENGLAND J. MED. 1838-1848 (2004).

[72] *Id.* at 1838.

[73] Kramer, *supra* note 15, at 8.

[74] *Id.*

[75] *See* Ben van Velthoven & Peter van Wijck, *Medical Liability: Do Doctors Care?*, 33 RECHT DER WERKELIJKHEID 1, 3 (2012), *available at* https://openaccess.leidenuniv.nl/bitstream/handle/1887/43246/bvv_2012_02.pdf?sequence=1.

[76] *Id.* at 4.

[77] *Id.* at 7-8.

standard set may become arbitrary. First, the judge is not a medical expert familiar with the realities of the work environment. Second, the evidence presented may not be exhaustive and could be subject to inaccurate interpretations. Lastly, the claimant may commit an error in presenting an expert witness. Again, as illustrated in *Cereno*, the Supreme Court ruled in favor of the doctor because the witness presented by the claimant was an anesthesiologist, not a surgeon, hence:

> Here, there were no expert witnesses presented to testify that the course of action taken by petitioners were not in accord with those adopted by other reasonable surgeons in similar situations. Neither was there any testimony given, except that of Dr. Tatad's, on which it may be inferred that petitioners failed to exercise the standard of care, diligence, learning and skill expected from practitioners of their profession. *Dr. Tatad, however, is an expert neither in the field of surgery nor of surgical practices and diagnoses. Her expertise is in the administration of anesthesia and not in the determination of whether surgery ought or not ought to be performed.*[78]

### C. Latent Factors: James Reason's Swiss Cheese Model

James Reason, Professor Emeritus of Psychology at the University of Manchester, was the progenitor of the "Swiss Cheese Model" of human error. In his theory, the problem of human error is divided into two areas: the person approach and the systems approach. The person approach focuses on the acts or omissions of nurses, physicians and other medical personnel arising from factors such as inattention, carelessness, negligence and recklessness.[79] The systems approach is based on the premise that humans are fallible and errors are to be expected even in the most well-equipped organizations. Mistakes are not the causes but are consequences of an "upstream" of factors not entirely due to human actions.[80]

The person approach is most common in medicine because people are perceived as the agents responsible for making the wrong or right decisions. Likewise, it more satisfying to blame someone rather than an institution.[81] A case in point, again, is Libby Zion's father who sought to put blame on anyone, even though the court found that understaffing was not the proximate cause of his daughter's death. However, based on the concept

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[78] *Cereno*, 682 SCRA 18, 29. (Emphasis supplied.)

[79] *See* James Reason, *Human error: models and management*, 320 BMJ 768-770 (2000), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117770/.

[80] *Id.*

[81] *Id.*

of defensive medicine, this one-dimensional approach fails to account for the other contributors to the error. It separates the act from the system context, and focuses on punishment rather than the removal of cause and preventive measures in the system.

The "Swiss Cheese Model" envisions a series of defenses, layers or barriers in the systems approach. Each slice of "cheese" represents one barrier or defense mechanism set up by the institution against potential errors. The holes typical of a slice of Swiss cheese represent potential hazards, in that when each slice and hole is lined up in a way that permits a straight line of "accident opportunities" to run through the holes, it then results in injury to patients. According to Professor Reason, the holes represent both the acts or omissions and latent conditions. Latent conditions are those inherent in the system such as decisions of hospital managers which could potentially result in harmful effects, and can be considered as another contributory factor in the commission of medical errors. These decisions might involve the creation of holes or weaknesses in the barriers such as time pressure, understaffing, inadequate equipment, fatigue, and inexperience.[82] These problems may not be immediately apparent and may be embedded in the system for years before they can be recognized as significant contributors to patient injury. While human factors are difficult to anticipate, latent factors can be remedied even before an adverse event happens.

## V. THE EUROPEAN WORKING TIME DIRECTIVE ("EWTD") AND THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION ("ACGME")

While some studies have generated inconclusive results on the relationship between lesser work hours and the incidence of medical errors, it cannot be totally disregarded. The working conditions in most parts of the Western world are quite different from the Philippines, and this may be an area for future study using the EWTD and ACGME as guides for a more feasible and effective approach to preventing medical errors.

### A. Summary of Pertinent Provisions

The EWTD was enacted in the United Kingdom in 1998 to regulate the average maximum number of hours that could be worked in a week, the

[82] *Id.*

duration and timing of rest periods, days off, and paid leave.[83] The main features of the law include a 48-hour maximum working time per week, and 11 consecutive hours of rest in any 24-hour period. The measure was well-meant but unfortunately, the results were unfavorable. The doctors were indeed able to get more time off work to attend daytime training seminars, but there was no significant improvement in the quality and continuity of care. Consequently, the European Union sought to give more flexibility to its member states in order give effect to its original intention. In 2008, an updated version of the law was passed, but this time, states were given the freedom to fix their own limits in the number of working hours to account for the different working conditions of each country.[84]

The United States enacted its own version of the EWTD in 2003, known as the ACGME. Its aim was to lessen the risk of fatigue-related errors by implementing work hour limits for doctors.[85] The regulation provides that residents can work no more than 30 consecutive hours, and no more than 80 to 88 hours per week, averaged over four weeks. However, in implementation, it was discovered that it was difficult to impose restrictions on "traditional" 30-hour work days that the doctors have already been used to. The study further suggests that the high incidence of fatigue-related errors will remain if these hours continue to be endorsed by the professional regulatory bodies. In contrast to the ETWD, the problem faced by the ACGME was in implementation because it was the policy-makers themselves who failed to take more effective action.[86]

Both the EWTD and ACGME may have been unsuccessful but possible areas for improvement have been discovered. Studies suggest that a more effective rationalization of services may be necessary to be able to implement the law. This will deal with the task of having to conduct further investigation into cost-effective methods for shortening working hours and at the same time addressing the problem of continuity of care. It is also important to account for the different specialties in the medical field and the number of hours necessary to balance the technical learning needed without overworking the workers. For example, it is necessary for those training in

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[83] *See* Peter Black, *The European working time directive*, 90 BRIT. J. OPHTHALMOLOGY 1082-1083 (2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1857406/.

[84] *See* European Foundation for the Improvement of Living and Working Conditions, *Revisions to the European working time directive: recent Eurofund research*, *at* http://ec.europa.eu/social/BlobServlet?docId=6474&langId=en (last visited July 9, 2018).

[85] *See* Christopher Paul Landrigan et al., *Effects of the Accreditation Council for Graduate Medical Education Duty Hour Limits on Sleep, Work Hours, and Safety*, 122 PEDIATRICS 250-258 (2008), *available at* https://www.ncbi.nlm.nih.gov/pubmed/18676540.

[86] *Id.*

surgery to perform as many operations as possible in order to hone their skills. On the other hand, those in internal medicine are most likely to be burned out. Policies may work if they are tailored to a specific area of medicine in order to achieve the desired effect of lessening patient errors. Recommendations have even gone so far as to consider making the most of the duty hours with other learning opportunities instead of shortening them.[87]

### B. Comparison with Existing Conditions in the Philippines and the Practicability of Applying EWTD and ACGME

The health sector in the Philippines operates quite differently in terms of working environment and work policies. In most hospitals, both public and private, doctors work approximately 36 hours per shift, every other day. This amounts to over 140 hours per week. In government hospitals, there are approximately 30-60 or more patients under the care of only one doctor regardless of the severity of condition. The same is true with private hospitals. These conditions are so far from the ideal that medical errors are almost expected. One main problem that most institutions, more commonly public hospitals, face today is understaffing due to financial constraints.

The biggest obstacle that may be encountered, similar to ACGME, is the implementation of policy renewal or strict standards of reform. Hospitals will be reluctant to change existing practice if doing so would increase the cost and radically change traditional practices. Nevertheless, the pitfalls of the EWTD and ACGME have for the most part been identified and these models are an ideal springboard for future action in practice.

## VI. MOVING AWAY FROM BLAME-BASED SYSTEMS

Like a rite of passage, the newest and youngest member of the team is usually the recipient of blame when mistakes happen in the workplace. A culture of blame, whether real or perceived, has been implanted in our consciousness. This is especially true in the field of medicine where the effects are sometimes irreversible, and doctors save face by shifting the blame to their colleagues. It is also because of this culture of blame that

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[87] Michael Lee, *On Patient Safety: Have The ACGME Resident Work Hour Reforms Improved Patient Safety?*, 473 CLIN. ORTHOPAEDICS & RELATED RES. 3364–3367 (2015), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4586212/.

health care workers are either too cautious and refuse to treat their patients, or they do not report adverse outcomes which might be worse.[88]

While patients are the primary victims of negligence, medical staff in some cases are the so-called "secondary victims" of a blame-based culture, because mistakes may affect them more deeply than one might think. The Pennsylvania Safety Collaborative Report of 2001 stated that "[m]any organizations need to break out of the 'blame and train' mentality that punishes individuals for errors and rarely looks beyond the underlying job designs or system malfunctions. In these environments, personnel tend not to report errors they can hide, and are hesitant to discuss them." As a result, there arises a "third victim": the hospital or health institution, which exhibits mostly knee-jerk reactions against the physician involved.[89]

Lawsuits, likewise, seek to put blame on individuals involved in the entire process that resulted in the adverse outcome such as nurses, nursing attendants, interns, residents and supervising doctors. Some plaintiffs may not entirely believe that these people are liable but the prospect of some compensation emboldens them to file a suit anyway.[90]

### A. Defensive Medicine

Defensive medicine "occurs when doctors order unnecessary tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability."[91] Defensive medicine has two aspects, namely: (1) positive defensive medicine, which involves supplying care that is not cost effective, unproductive, or even harmful; and (2) negative defensive medicine, which involves declining patients that might benefit from care. It could result in physicians deciding to exit the profession altogether. Negative defensive medicine incentivizes rendering less care to avoid medical errors.

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[88] Martin Elliot, *To Blame or Not to Blame? The Medical Profession and Blame Culture*, GRESHAM COLLEGE WEBSITE, *at* https://www.gresham.ac.uk/lectures-and-events/to-blame-or-not-to-blame-the-medical-profession-and-blame-culture (last visited July 9, 2018).

[89] *See* Martin Elliott, *To Blame or Not to Blame? The Medical Profession and Blame Culture*, Gresham College Website, *citing* Pennsylvania Safety Collaborative Report 2001, *at* https://www.gresham.ac.uk/lectures-and-events/to-blame-or-not-to-blame-the-medical-profession-and-blame-culture (last visited Aug 5, 2018).

[90] *See* Troyen Brennan & Michelle Mello, *Patient Safety and Medical Malpractice: A Case Study*, 139 ANNALS INTERNAL MED. 267-273 (2003), *available at* http://annals.org/aim/fullarticle/716661/patient-safety-medical-malpractice-case-study.

[91] US CONGRESS OFFICE OF TECHNOLOGY ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE 1 (1994).

Considering these factors, one might question then, whether tort law will positively or negatively impact the doctor's behavior and level of care.[92]

The concept of defensive medicine is more common than people realize. Doctors are rendered unable to fulfill the Hippocratic Oath because of their desire to avoid being the subject of embarrassing and long drawn-out suits. A US study shows that 75% of doctors order more tests, medicines, and procedures than are necessary just to make sure they are rid of liability if anything untoward happens.[93] It is a circular and ineffective way to avoid the commission of errors, and it frustrates the aim of prevention and learning. It has been suggested that the only way to remove this unhealthy practice among doctors is to make it "impossible for doctors to be sued."[94] These no-blame systems have been the subject of consideration not only in a few states in America, but have also been gradually adopted in Europe.

## B. Open Disclosure and No-fault Compensation Systems

In administrative law, the doctrines of primary jurisdiction and exhaustion of administrative remedies are applied in determining cases that require expertise and specialized training. The Supreme Court declared:

> The doctrine of primary jurisdiction holds that if a case is such that its determination requires the expertise, specialized training and knowledge of the proper administrative bodies, relief must first be obtained in an administrative proceeding before a remedy is supplied by the courts even if the matter may well be within their proper jurisdiction. It applies where a claim is originally cognizable in the courts, and comes into play whenever enforcement of the claim requires the resolution of issues which, under a regulatory scheme, have been placed within the special competence of an administrative agency. In such a case, the court in which the claim is sought to be enforced may suspend the judicial process pending referral of such issues to the administrative body for its view or, if the parties would not be unfairly disadvantaged, dismiss the case without prejudice.

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[92] *See* Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform*, 25 J. ECON. PERSP. 93-110 (2011)

[93] Hal Sherz & Wayne Oliver, *Defensive Medicine: A Cure Worse Than the Disease*, FORBES, Aug. 27, 2013, *available at* https://www.forbes.com/sites/realspin/2013/08/27/defensive-medicine-a-cure-worse-than-the-disease/#40c4754f7c95.

[94] *Id.*

> The objective of the doctrine of primary jurisdiction is to guide the court in determining whether it should refrain from exercising its jurisdiction until after an administrative agency has determined some question or some aspect of some question arising in the proceeding before the court.[95]

In comparison, medical negligence cases require expertise, specialized training and knowledge as well. Designating specialized bodies under a no-fault system is an effective and more efficient way of dealing with all the issues in medical malpractice.

Because of the uncertainties that arise from differing decisions of the Supreme Court based on principles of tort, there should be a shift from the traditional blame-based system to one which is more open and competent in evaluating each case. The "Patients' Compensation System," proposed in Thailand, was first set up as a way to prevent soaring costs of medical care, and to address the problem of the practice of defensive medicine. This no-fault system is essentially an out-of-court settlement where patients get what is monetarily due them, without needing to prove negligence in court, from a fund that doctors contribute to on a regular basis. A process involving an independent medical review panel evaluates each case and makes recommendations based on its findings. If the victim or his family disputes the findings, the case is brought to an administrative law judge who makes a decision based on the findings of the medical panel and decides accordingly. A database is made available to track each case and identify best practices to prevent future occurrences of injury.[96]

### C. Health Courts

Perhaps the most radical yet unexplored alternative to the tort system that was proposed by the Harvard School of Public Health are "health courts", where cases are handled administratively instead of judicially.[97] According to the proposal, there are five major components of a health court. First, compensation is determined by specially trained judges. Second, the compensation will be based on a broader standard of care but one that does not approach strict liability. The focus of the decision-making is on prevention or avoidance of injury. Third, the grant of compensation is guided by expert testimony and scientific literature, and is geared towards *ex*

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[95] Province of Aklan v. Jody King Construction & Dev. Corp., G.R. No. 197592, 711 SCRA 60, 70-71, Nov. 27, 2013.

[96] Armbrecht, *supra* note 55.

[97] *See* Michelle M. Mello et al., *"Health Courts" and Accountability for Patient Safety*, 84 MILBANK Q. 459–492 (2006).

*ante* determinations to prevent common adverse events. Fourth, the knowledge gained from expert testimony and current scientific evidence is correlated with previous practices to expedite decisions for specific kinds of injuries.[98] In health courts, a patient may file a case with the hospital itself or with a liability insurer, and a panel of medical experts are tasked to evaluate the case. Any act of the physician involved that is not in accordance with best practices would be deemed compensable. This method is also known as the "avoidability standard of care", because patients are compensated for injuries which could have been avoided in consideration of the medical technology available today. Finally, in view of continually developing the system, guidelines are formed to address other possible situations or injuries with a view towards prevention of injuries in the future.[99]

Like the Patients' Compensation System, health courts involve a variation of liability insurance, which is different from the normal method of granting damages in long and costly trials. This is especially significant in the Philippines where cases are not resolved immediately, thus resulting in costly litigation, and the decline in the value of the compensation for victims over the years. On a more practical view, compensation will be of better use to patients who have suffered injuries, or to families left behind if the patient is deceased. A no-fault system of compensation is a better starting point for prevention than the usual determination of fault. The proposed system may result in marked reduction in the costs involved in hiring expert witnesses, pretrial discovery, motion practice, and lawyer preparation.[100]

### D. Shifting the Legal Response: Damages to Prevention

Medical errors do not involve moral culpability in most cases, which is why punitive measures such as a legal response should not be the first and only remedy. It does not mean, however, that negligence should be tolerated. There are many elements relating to both the healthcare system and the physician himself that contribute to medical errors, and the courts may not be able to address all these issues at all times.[101] In the Philippines, courts have the discretion to award damages, but there are no serious efforts to prevent medical errors through laws, and to promote safe practices.

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[98] *Id.*

[99] *See, generally,* Philip Peters, Jr., *Health Courts?*, 88 B.U. L. REV. 227 (2008).

[100] *Id.* at 259.

[101] *See* Alan Merry, *How does the law recognize and deal with medical errors?,* 102 J. ROYAL SOC'Y MED. 265-271 (2009), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2711199/pdf/265.pdf.

Instead of seeking judicial remedies, an open disclosure method should be encouraged where an acknowledgment of the wrong committed is made without threat of suit. In this method, all authorized parties have the opportunity to examine all records of the case to open the floor to dialogue with the opposing party facilitated by a panel knowledgeable of the issues. In a health court model, patients have a right to examine medical records otherwise deemed privileged. In *Li v. Spouses Soliman*,[102] the Court rendered a decision based only on testimonial evidence because no records were presented by the hospital during trial. While the Supreme Court ultimately ruled in favor of the plaintiffs, such a situation may prove fatal in other cases. Lawyers are not generally needed, but may be allowed in case the issues are complex, and the patient might need assistance in presenting the claims to the panel. Litigations costs would be lessened because while parties will be permitted to have legal representation if desired, they could easily proceed without the assistance of counsel in most cases.[103]

In the health court model, the panel is composed of insurers, hospital representatives, and a trained judge. During the hearing, the rules of evidence are relaxed, and legal representation is only optional for the parties. The judge renders a decision with the assistance of court-appointed medical experts in the related clinical specialization. The insurers would pay the compensation, and if any of the parties dispute the decision, they may appeal to a higher-level administrative body, and ultimately to the courts, both bodies giving due regard to the findings of the health court's findings.[104] When compared to our current legal set-up, the most significant difference is the institution of a trained body of experts as the first forum, where the judge is trained and guided by medical experts so that the decision is more comprehensive and less antagonistic. In our country, we can adopt this model by forming a state-appointed group composed of DOH representatives, medical doctors, nurses, insurers, and personnel from the Department of Social Welfare and Development who will guide the judge in the hearing and in decision-making. Since the body will be meeting only on an *ad hoc* basis, state resources will not be burdened when compared with the cost of prolonged litigation in the long run.

An advantage of health courts is the achievement of reliable and uniform decisions in a shorter period of time. The compensation awarded will be based on standards such as the number of days hospitalized, salaries, and the amount of actual expenses, with due consideration to expenses

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[102] G.R. No. 165279, 651 SCRA 32, June 7, 2011.

[103] Mello et al., *supra* note 97, at 465.

[104] *Id.*

already covered by medical insurance. Here, health courts would determine compensation by examining whether or not the incident was avoidable, and whether it falls under the lists of specific "accelerated-compensation events" ("ACEs"), which are injuries that are presumptively deemed avoidable based on strong *ex ante* determinations that they would not normally occur when optimal care was provided. The ACE lists would be developed by an expert consensus process, and relying on the best available evidence. In other words, events that matched the specifications and clinical circumstances of an item on an ACE list would be eligible for expedited compensation.[105]

Another advantage of health courts is their accessibility to a greater number of those affected; their claims are carefully studied by the appropriate tribunal to be fair to both the claimant and the physician. The "screening process" will involve a group of experts that would review the event, and thereafter render a judgment on the compensability of the event. If the injury is deemed compensable, the insurer would make an offer of compensation. The offer would then be reviewed by an administrative law judge specializing in health court adjudication, whose decision will be based on court-appointed medical experts in the relevant area of practice.[106] The claimant would have the option of consulting a lawyer to determine the fairness of the offer. A third advantage of the health court model is the lowering, or at least standardizing, of the costs which is fairly difficult in the tort system.[107] The most important contribution of a health court is the aim to promote safer practices. A few countries, particularly New Zealand, Sweden and Denmark, are now using a centralized system where medical negligence cases are logged into a central database in order to analyze data, identify priority areas for safety improvement, and to perform safety analyses using the database.[108]

Admittedly, there are many difficulties in sustaining the no-fault, no-blame system. It will be challenging to promote a system where blame is confined to those faults and errors which are fundamentally or morally wrong. In the end, a finding of fault and damages should not be the end-all of medical malpractice suits. The goal must be to promote safer practices by targeting those who are in the position to establish key policies with the aid of a qualified group of individuals well versed in common practices in medicine.

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[105] *Id.* at 467.
[106] *Id.* at 464-465.
[107] *Id.* at 470.
[108] *Id.* at 480.

## VII. CONCLUSION AND RECOMMENDATIONS

It takes a group of highly skilled people working together to achieve a common goal or outcome in running a healthcare system. The preceding discussion is a selection of the many options that can be used in reforming the tort system approach to medical malpractice. The emerging developments in medical science today make it a system that is becoming incompatible with the standards set by the courts in the past. The conditions of healthcare are now radically different because of the increased number of factors to consider when errors occur.

The most effective system for both the physician and the patient is one that acknowledges that, because of human nature, errors will happen. Therefore, it is important that continuous evaluation is made in order to spot and prevent these errors. Even if physicians are cautious, there is still a possibility that a step in a procedure might be missed because of fatigue, or there is a change in hospital policy that could lead to undesired outcomes. It is not wise to immediately attribute fault to practitioners for making these errors which are not always the result of their negligence, as they could happen in a high-pressure and technical profession. Conversely, patients should not have to bear the additional burden of having to file a case that might be more disadvantageous in the end. The best systems are those that acknowledge human error and build on contingencies to address the problem as a whole.

While the tort system has proven to be effective in situations where there is clearly a negligent act, it has its limitations with regard to the conditions of each individual and the causes for his acts or omissions. The current system can only penalize physicians and compensate patients for their injuries. Even then, there are still decisions that are not favorable to the injured patient, but litigation is the most common, and sometimes, the only way for them to have a chance to be compensated for their loss. As a result, the courts are burdened with malpractice suits that cover various fields of specialty, and which require large amounts of resources and time to properly examine. In the tort system, plaintiffs are disadvantaged by the superior ability of well-resourced defendants to withstand protracted litigation and its costs.[109]

It will take time to see any changes reflected by tort reform measures, primarily because it is likely that hospitals will be reluctant to

[109] *Id.* at 469.

change what they already know. An effective system would be centered on appropriate compensation and improvement of conditions, rather than on punishment. The government, through the proper agency, must focus on implementing reforms to dispose of medical malpractice cases as quickly as possible. The main goal is to eliminate unstudied lawsuits, either by reducing the incentive to sue or by making it less likely for a baseless suit to move forward.

An injury merits compensation as a matter of right, and should include other costs such as loss of earning capacity arising from the accident. But the "punishment" should stop there. An appropriate analysis of why things went wrong and a concerted effort to correct any failings in the system to minimize the likelihood of a recurrence is essential.[110] Advocates argue that reporting information about injuries to centralized systems is crucial to building an evidence base for learning why errors occur, and how they could be prevented. [111] This approach will be more beneficial in promoting safer practices and implementing preventive measures to lessen the occurrence of errors in practice.

In the move towards a more progressive system, tort law will still serve as a guide for the existence of injury as a result of a truly negligent act, but it will no longer be the only basis in deciding the liabilities of the parties involved. The health court's emphasis is on transparency, and the diminished need for confidentiality in a system that does not revolve around blame.[112] In health courts, fostering a culture of disclosure, encouraging root-cause analyses by both hospitals and insurers, compiling the results of these analyses and additional findings by the health court in a database maintained by the government and shared with qualified researchers, and eventually developing a national database of avoidable injuries would constitute the primary patient safety benefits of moving to a health court scheme.[113] If the priority is compensation, and prevention, dealing with the issue with simplicity and accuracy is the key. Focusing on those who have the influence or authority to make changes will be the first step in promoting safety within the system and taking it out of judicial processes.

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[110] *Id.*
[111] *Id.* at 472.
[112] *Id.* at 478.
[113] *Id.* at 483.