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Medical Negligence and its Importance in the Zambian Health System

UNZA, LUSAKA

THE UNIVERSITY OF ZAMBIA
SCHOOL OF LAW

L410 OBLIGATORY ESSAY

TITLE: MEDICAL NEGLIGENCE AND ITS IMPORTANCE IN THE ZAMBIAN HEALTH SYSTEM

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This thesis is submitted in partial fulfillment of the award of A Batchelor of Laws Degree (LLB) in the School of Law at the University of Zambia.

January 2007

SUPERVISOR'S CERTIFICATE

This is to certify that this Directed Research Paper entitled: **Medical Negligence and its Importance in the Zambian Medical Health System**, Has met the Academic standard and has satisfied the regulations governing the presentation of a Directed Research Paper in the School of Law at the University of Zambia.

Supervisor's Name: Nicholas Khan-Fogel

Signed: .....

Date: 12/1/07

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DECLARATION

I, **TAMARA MABEL GONDWE – COMPUTER NO. 79081461** do declare hereby that I am the author of this Directed Research Paper entitled: **Medical Negligence and its Importance in the Zambian Health System;** and confirm that it is my original work. I further declare that due acknowledgement has been given where other scholars' work has been used. I verily believe that this research has not been previously presented in the school for academic purposes.

Student's Signature: .....

Date: .....12/01/07.....

DEDICATION

Without the power of the Holy Spirit

This would not have been possible....

To my son Euan who has complete faith in all I do,

My family whose support I value.

Thank you!

Psalms 23

Acknowledgements

The past four years have been a ***'learning curve'*** literally for me, not only have I gained knowledge, but have come to realize my potential, through perseverance and my stubborn determination to become a ***'Learned person'***! Sometimes our calling in life comes at a later stage in our development – never in my growing years did I ever think about becoming a lawyer – but a lawyer I am to become and for this I thank God for his guidance.

I have received support from areas and people I would never have thought of asking for help but who have come forward willingly and offering their knowledge, support and advice. To my mentor, Mr. Mumba Malila, for whom I have a lot of admiration and respect, for always giving me his time and attention, whether it was an academic problem I had, or a personal problem I was grappling with, his advice was always well appreciated. Professor Alfred Chanda, Professor Carlson Anyangwe and Mr. John Sangwa – for throwing lemons at me and encouraging me to turn them into lemonade. My peers, Kasuba, Monica, Katrina, Marjorie, Derek, Ronald, Vischer, Mumba, Doris, and Nchimunya, who were there for me whether I needed them or not, in good times and hard times, in tears and in laughter. To Benson, Alfred, Friday and Kazimbe for the data provided sometimes at very short notice and lastly to my lecturers and tutors too numerous to mention, for their teachings and time.

I have had very little social time during my studies and have deprived my family and friends of precious quality time; this has not affected our relationships and has in fact

made them look at me with respect – some I have even influenced enough to study as well, like Mwewa for one. My mother Khumbata, my sisters, Yananga, Tamikani, Ndavuka, Mbaheni and Rumbani, my brothers, the late Suzygo, Mejar and Mwiza, my nieces and nephews too numerous to mention, Zondiwe and Tawana for the constant encouragement, my cousins, Patani Mhone and Michael Gondwe for being a source of inspiration.

The Bible says in the book of Proverbs and I quote: "he who finds a friend finds a treasure" end of quote. I have wonderful treasure treasures in my life, Gwen, my soul mate, who thinks the world of me and I can do no wrong in her eyes, Agnes, who was, is and will always be my best friend, Maureen, far but always in my heart and Sandy for always being there for me.

The most important person in my life – my son Euan, who is my love, my pain, my friend and my life, all this was for you and I hope this will make you realize that whatever you set your heart on achieving can be done, no matter how rough the road will be.

Saving the best for last....if my father, Godfrey Mwizakwacha Gondwe (GMG) could see me now, he would be so proud of me – Dad, you were the most influential person in my life, I am a go-getter because of you and your no-nonsense approach to life and people have helped every step pf the way. I loved you in life and I love you even more in death!

To all of you, my heartfelt gratitude and may the good Lord bless you always.

TABLE OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
UTH	University Teaching Hospital
WLR	Weekly Law Reports
AHA	American Hospital Association
MAPA	Medical and Allied Professions Act
MCZ	Medical Council of Zambia
UNZA	University of Zambia
ZR	Zambia Law Reports
HC	High Court
BC	Before Christ
PTY	Private Limited
AC	Appeal Cases
USD	United States Dollar
HIV	Human Immune Virus
UK	United Kingdom
GBP	Great British Pound
K	Kwacha
ADR	Alternate Dispute Resolution
ZARAN	Zambia Aidslaw Research Advocacy Network
CHAZ	Churches Health Association of Zambia

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PREFACE

The health system in Zambia has become a major source of income for both private and public institutions – the focus has changed from providing a service into a profit making industry. Access to treatment is one of the issues that are at the top of the health agenda in Zambia, however, the difficulty people with health problems face in gaining access to treatment and good health facilities has raised questions regarding the realization of the right to health in Zambia.

It is against this back drop that this research proposal seeks to appraise both the efficacy and efficiency of the Health sector and its administration in Zambia. This proposal implores the role of the law in protecting people against in-justices, the sick in receiving proper care and the current situation relating to negligence and its repercussions in Zambia's public and private health system. It could be argued that the objectives and aims have been greatly compromised by the springing up of so many privately owned clinics and medical centers and hospitals, but it cannot be confirmed how helpful they have been in addressing the then perceived shortcomings, gaps and some unclear provisions. In the light of the foregoing one sees the need to conduct an appraisal on the current health Act.

ABSTRACT

Physicians historically have set their own standards of care and their conduct has usually been judged by comparing it to that of other physicians. "Ethical" canons or codes generally focused on professional etiquette and courtesy toward fellow physicians rather than on relationships with patients. The Hippocratic Oath was a notable exception, but its provisions were only ascribed to by a minority of Greek physicians.

The law has become intimately involved in medical practice only in the 20th century. Until recently legal medicine, or forensic medicine, was a field devoted exclusively to the uses of medicine in the courtroom, primarily in two settings: forensic pathology and forensic psychiatry. The pathologist has traditionally been asked to determine and testify to the cause of death in cases of suspected homicide and to aspects of various injuries involving crimes such as assault and rape. Pathological testimony may also be required in civil cases involving, for example, occupational injury, negligent injury, automobile accidents, and paternity suits

Since 1960 the legal climate has changed drastically. Civil lawsuits alleging medical malpractice have become a fact of professional life for many Western physicians. Issues formerly relegated to ethics, such as abortion and termination of treatment, also have become important civil rights issues in courtrooms across the world, as have issues of informed consent and patients' rights. Wide-ranging campaigns aimed at arresting the spread of infectious diseases, such as acquired immune deficiency syndrome (AIDS), have involved the legal system in issues of privacy, confidentiality, quarantine, and research using human subjects.

Doctor's Oath

"Do you as a holder of the degree of Bachelor of Medicine and Bachelor of Surgery of the University of Zambia, solemnly declare:

That you will exercise your profession to the best of your knowledge and ability for the safety and welfare of all persons entrusted to your care;

That you will not knowingly or intentionally do anything or administer anything to them to their hurt or prejudice;

That you will not employ any secret method or treatment, nor keep secret from your colleagues any method or treatment that you consider beneficial;

That you will not advertise yourself nor permit yourself to be directly or indirectly advertised;

That in your relations with your colleagues you will conduct yourself as becomes a member of the honourable profession or medicine?"[1]

[1] Sekelani Banda, *A Handbook of Medical Ethics for Medical Students and Health Professionals* (1998) Zambia Medical Association p.iv

CHAPTER ONE

1.0 Introduction

This chapter will look at Negligence as a legal concept, its essential elements and the liability involved in this tort. A brief historical background will be given to professional negligence, its repercussions and the standard of care expected from a reasonable man. The special standards that are expected and are appropriate to professionals will be highlighted with a specific bias to the medical profession and critically analyze what is deemed to be medical malpractice and the duty of care required of medical practitioners.

1.1 Negligence as a Legal Concept

The definition of **NEGLIGENCE** as in the case of **Blyth v Birmingham Water Works Company**[2] and in Alderson B's classic words:[3]

> ***"Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do, for example a manufacturer, doctor or driver. The basic principle is that it is incumbent, in all circumstances on everyone to exercise prudent care to safeguard all ones' fellowman against any kind of detriment."***

[2] (1856) 11 Ex 751 @ page 784
[3] Charlesworth *supra note* 1 at p.441 para. 6-07

Under the law of tort, negligence is the largest and most extensive tort – this is the breach of a legal duty to take care which is owed by everyone to his neighbor. Intention, motive and malice are irrelevant in the tort of negligence and to prove that there was negligence three main elements need to be present:

- **The owing of a duty of care;**
- **The breach of a Duty of Care;**
- **The resultant undesired damage of that care.**

The courts have always taken the view that a careless person should not have to compensate all the people who suffer as a result of his conduct. For example when a van driver is injured due to the negligence of another driver several people may also be affected. There may be a witness to the accident who suffers nightmares as a result of his experience and a trader to whom the driver was delivering the goods may lose profits because of inadequate stock. In such cases the task of the court is to consider the interests of the victims whilst being fair to the careless person.

In some situations the plaintiff will not need to prove a breach of the duty to care. The maxim ***res ipsa loquitur*** [4] applies when:

- The 'thing' is under the control of the defendant;
- The defendant has knowledge denied to the plaintiff; and
- The damage is such that it would not normally have happened if proper care had been shown by the defendant.

[4] *The thing speaks for itself*

If these requirements are fulfilled there is prima facie evidence of a breach of duty. The burden of proof is then shifted to the defendant, who must prove that he did show reasonable care. The maxim does not always apply and was considered in the case of **Mahon V Osborne.**[5] A swab was left in a patient's body after an operation. Clearly the patient could not prove a breach of duty, since he was under an anesthetic, however, the presence of the swab raised the inference of a breach of duty and the surgeon was unable to show that he had used reasonable care and was accordingly held liable.

Once a practitioner has undertaken to give his services, he has a responsibility to give proper service or exercise a degree of skill and care commensurate with his status and experience.

A medical practitioner must always maintain the highest standard of professional conduct and must practice his profession uninfluenced by motives of profit.[6] He must always bear in mind the obligation of preserving human life and that he owes a duty to the patient; when he fails he may be found to have been guilty of professional negligence and if harm has resulted, damages may be levied against him.

The term malpractice involves in addition to negligence an ignorant or willful departure from approved practice.[7] The fact that the patient has failed to make a complete recovery raises no presumption of lack of proper skill and attention. Doctors should not be held responsible for every unfortunate accident that occurs

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[5] (1939)

[6] *Professional Conduct and Discipline: Fitness to Practice.* Medical Council of Zambia (1995)

[7] *Supra note 5*

in the practice of their profession neither should they be held liable for certain natural calamities or problems that are far beyond their control.

The University Teaching Hospital experiences numerous problems which contribute to the high death toll, including medical malpractice. Another notable problem is overcrowding because of the lack of alternative government hospitals in Lusaka. This has led to low nursing and medical standards at the University Teaching Hospital.

Accident victims die prematurely or have lasting impairments because of the lack of care of hospital medical staff. Many lives could be saved with aggressive and prompt emergency care provided through a pre-planned and organized system of intervention. Unfortunately most hospitals are not prepared with the therapy and philosophy to manage the critically injured patient.

The major special attributes of professional negligence cases, therefore, involve the statement of care to which the defendant is held. As a follower of a profession or a vocation he holds himself out to the public as having the requisite skill to practice it. He must, therefore, possess and exercise skill. The word 'skill' includes not just manual dexterity but also knowledge and training suitable for the profession.[8]

[8] *Skill is something more than the mere minimum competence required of any person who does an act.*

An examination of the tort of liability of professional people necessarily involves two areas:

1. an examination of factual situations peculiar to the activities of the various professions; and;
2. an analysis of the theoretical basis for professional liability as distinguished from any other form of tort liability.[9]

In this respect, the starting point would lie in the question whether there are in fact any general principles of professional liability beyond the ubiquitous negligence standard of "the reasonable man"; whether what is being discussed here is not merely the particular application of otherwise general law.[10] The question demands some analysis of the negligence standard itself.

1.2 The Structure of a Reasonable Man

Negligent conduct involves unintentional harm resulting from a lack of care. Since intent is not being determined to establish fault, some standard of carefulness must be established against which individual conduct may be measured. The pertinent question, however, is how is this to be done? The first criterion one might expect is that of the general average of the population. But the law says this is not enough. Negligence is not judged on the basis of average carefulness, or average prudent conduct. There is a certain "ought ness" in this requirement; a demand that people must act with better than merely average

[9] Scrutton *supra note* 14 at p.1
[10] Ibid

conduct to protect others from harm. According to judges, the standard of care requires reasonableness, or, a man must exercise average reasonable prudence.

The standard of care in negligence cases is thus expressed in words. But how is it applied to the person before the court? Does the judge use himself as the object of identification or does he use the person before the court on a primary charge of negligence?

It is trite law that the judge cannot use himself, that is, he cannot judge the case on the basis of what he himself would have done under particular circumstances. The second question is more difficult – does he use the defendant?[11] In a way yes, he does, but not in an entirely subjective way. There is much more of an objective nature to this test. Therefore, the law suggests to the courts or judges that they first establish what the ordinary reasonable prudent man would have done under particular circumstances then compare these requirements to what was actually done by the defendant. In so doing, the court or judge is forced to divorce the standard from either themselves or the defendant and to apply it through a fictitious entity which is in fact a reasonable prudent man.[12]

1.3 Standard of Care

As already submitted herein, the standard of care is a question of law but whether or not, in any given case, the standard has been attained is a question

[11] Pound *supra note* 18 at p.2 (*the defendant where primary negligence is at issue)*
[12] Pound *Supra note* 18 at p.2

of fact[13] for the judge to decide, having regard to all the circumstances of the case.[14] Usually, the standard is proportioned to the gravity and imminence of the risk. This is not invariably the case, because the law occasionally lays down different standards to be applied, when the risk is the same. For example, the standard of care required from a motorist is to drive with reasonable care, but if he approaches a pedestrian crossing, he must take much more care than usual.[15]

The ordinary standard of care, which is adopted, is what is called "reasonable care," namely that of a reasonable man. However, the application of the standard of reasonable care is only made if it is explained and to what amount of care the law regards as reasonable under the circumstances of the case being tried.

1.4 Special Standards Appropriate to Professionals

Where special skill is required for a task a reasonable man would not be expected to attempt it, unless he possesses the skill in question. In the event that he undertakes the work, he is bound to exercise the skill and competence of an ordinary competent practitioner in that calling. Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He or she does not undertake, if he or she is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he or she will perform a cure; nor does he or she undertake to use the highest possible

[13] Charlesworth *supra note* 1 at p.2
[14] *Kite v Nolan* (1983) R.T.R. 253, C.A.
[15] *Bailey v Geddes* (1938) 1 K.B. 156

degree of skill. There may be persons who have higher education and greater advantages than he or she has, but undertakes to bring a fair, reasonable and competent degree of skill.[16] The same rule applies to any man who exercises a skilled trade or business. In ***Bolam v Friern Hospital Management Committee,***[17] McNair J. noted that where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on top of a Clapham Omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest skill; it is well established law that it is sufficient if he exercises the ordinary skills of an ordinary competent man exercising that particular art.

It follows, therefore, that where a person holds himself out to be competent to do some special kind of job. According to Charlesworth in his work on negligence, an action for negligence will lie for damage which has been caused by the failure to exercise due care and skill or by proving that the defendant did not possess the requisite skill or by showing that although he possessed it, he did not exercise it in the particular case.[18]

The learned **Judge Magnus** observed that **Tindal CJ**, summed the care and skill required of a professional man. Magnus J. further observed that in the case of

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[16] *Lanphier v Phipos* (1838) 8 C. & P. 415. *per* Tindal C>J> *Greaves & Co. (Contractors) Ltd v Baynham*
[17] (1957) 1 WLR 1098 at 1100, *per* Lord Denning
[18] *See* Keeler, "Paying for Mistakes – Professional Negligence and Economic Loss", 53 A.L.J. 412

medical practitioners the standard of care and skill required is that of the ordinary competent medical practitioner and it is a defence. In this regard, he relied on Alderson B's classic words in the definition of negligence.

1.5 Medical Negligence

Medical negligence is a form of professional negligence. It has been noted that professional negligence, as a term, includes negligent conduct on the part of those following four traditional learned professions – doctors, lawyers, ministers and teachers. Thus, what is in issue hereunder is the liability of doctors for negligence in the practice of medicine. Medical negligence is blight on the otherwise superb medical profession. It occurs when an individual in the medical profession does not fulfill his duties to take care of a patient in a standard manner, and is commonly referred to as medical malpractice.[19] Medical liability is not only an important subject, but also one of extreme current interest to physicians and attorneys, the world over. The point to note, however, is that while medical practice may present the opportunity for a civil claim, the nature of a claim against a physician for this act is identical to that which may be brought against any person dealing with the public.

Medical Negligence was considered in the High Court decision in the case of ***Cicuto v Davidson and Oliver.***[20] The plaintiff in this case was a personal

[19] www.medicalmalpractice.com/case review.cfm
[20] (1968) ZR 149 (HC)

representative of the deceased child and brought an action claiming damages against the defendants, alleging negligence in that:

a. they failed to take any or adequate steps to diagnose the child's illness, namely intussusceptions of the large bowel;

b. they failed to obtain an X-ray of the child's stomach, which, the plaintiff says would have revealed the child's complaint;

c. they failed to accede to the fathers' request for an X-ray;

d. they failed to take steps to remove or cure the intussusceptions which was readily and easily curable by surgery; and;

e. they allowed the child to remain without any proper diagnostic treatment from the morning of 31st August 1967, until his death.

In effect they claimed damages for pain and suffering, damages for loss of expectation of life, and special damage by way of funeral expenses and hospital expenses.

1.6 What then is Medical Malpractice?

The only act in medical practice that may properly be termed malpractice is negligence in the care of a patient. Probably the most common tort committed in our society is negligence. The essence of negligence is failure to exercise due care, the standard of care is that which one might expect a reasonable prudent person to exercise under the circumstances. When negligence is said to occur in the practice of medicine, the essence of the act is failure to exercise such care

and skill as might be expected from the average practitioner in like circumstances.[21] Medical malpractice therefore, is a doctor's failure to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances.[22]

Medical Negligence may occur in different forms and may include:

- Surgeon Negligence – failure of a surgeon to properly conduct the surgery required;
- Medication Negligence – prescribing the wrong medication;[23]
- Oral Surgery (Dental) Negligence – performance of wrong or faulty dental works and;
- Nurse Negligence – a nurses' lack of nursing quality.

1.7 The Care required of Medical Practitioners

The words allegedly formulated by the father of medicine in what is known as the *"Oath of Hippocrates"*, define the duties, which physicians have sworn to perform towards those whom they undertake to treat. The *Oath of Hippocrates* has been adapted and adopted by the University of Zambia and is otherwise known as the Doctor's Oath,[24] and like many other oaths, however, noble as the sentiments expressed, is not sufficient to provide protection for the public.

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[21] Mere mistake in diagnosis is not negligence. Honest error in judgment is not negligence, nor is negligence necessarily neglect.
[22] *Supra note* 16
[23] *Supra note* 16
[24] Sekelani Banda, *A Handbook of Medical Ethics for Medical Students and Health Professionals* (1998) Zambia Medical Association p.iv

To sum up the position of medical liability, Magnus J. quoted Lord Denning LJ., in ***Roe v Minister of Health***[25] where two plaintiffs claimed damages for paralysis brought on by a contaminated spinal anesthetic. Lord Denning said:

> *"the two men had suffered terrible consequences that there was a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens wrong. Doctors would be led to think more of their safety than the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only misadventure"*

1.8 Jurisprudence

Zambian law recognizes negligence by medical practitioners and in that regard section 234 of the Penal Code Act[26] provides that a person is not criminally responsible for the performance in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patients' state at the time, and to all the circumstances of the case. It must be noted however that the negligence at issue is one in which the defendant goes beyond a mere matter of compensation

[25] (1954) 2 All ER 131
[26] Cap 87 of the Laws of Zambia

between subjects and shows such disregard for life and safety of others as to amount to a crime against the State and conduct deserving punishment.[27]

Other conflicts with legal systems arise because doctors have recognized that their responsibility to their patient takes precedence over all others. National and international medical associations have, for instance, advised doctors in countries where torture is legal that they must not be party to it by performing medical examinations to ensure that a prisoner is fit to be tortured. They have also warned doctors against being involved in any police procedure where, without their patient's consent, they could be asked to do something not in their patient's interest.[28]

1.9 Summary

This chapter has attempted to discuss negligence as a legal concept. It has further attempted to appreciate the concept of professional negligence, with a special bias towards medical negligence, which is the thrust of this essay. The Zambian legal system has attempted to address medical negligence.[29] However, the approach hitherto taken has not attracted public confidence; hence the lack of medical negligence related litigation. It, therefore, remains to be seen whether the changing world approaches to medical negligence will influence law, policy and practice in Zambia.

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[27] *The People v Zulu* (1968) ZR 88 (HC) *per* Evans J
[28] *Medical Jurisprudence,* Encyclopedia Britannica 2005 Ultimate Reference Suite CDRom
[29] *Supra Note* 17

CHAPTER TWO

This chapter will highlight all intricacies between Law and society. This will look at the doctor – patient relationship and their respective rights and duties. The chapter will analyze the appreciation of medical negligence in relevant Zambian legislation, the provisions made under the Constitution and what are the resultant repercussions under the Medical and Allied Professions Act and the Penal code. The role of Insurance will be highlighted in medical negligence and the ethical considerations vis-à-vis public interest.

2.0 Introduction

The critical issues of medical negligence in so far as they are relevant to this paper include the gap between relevant law and society, appreciation of medical negligence in relevant Zambian legislation, role of insurance in medical negligence and ethical considerations. Thus, this chapter provides a brief discussion of the said issues.

2.1 Gap between Law and Society

The problem at hand is historical. At Independence, Zambian society became divided, not on racial lines but by a line between the formal and informal which effectively translates into a gap between law and society.[30] It is submitted that the colonial legacy is largely responsible for the general lack of appreciation of the law as it relates to medical negligence. The point is that generally the Zambian

[30] Dr M.M. Munalula, *'A Critique of the Legal Framework Governing Sovereign Debt in Zambia'* Zambia Law Jounal, Volume 33, 2001 at p. 63

society, more often than not, lacks awareness in terms of patients' rights and duties and doctors' duty of care. If a patient is well informed and knows what therapies and drugs have been ordered, he will be in a good position to cooperate with the medical staff in preventing medication errors.

The traditional role of the patient in the doctor-patient relationship was to accept passively the doctor's recommendation for therapy.[31] The patient was not encouraged to ask questions and had little recourse if the proposed therapy was not acceptable. Persistence of this passive patient role into modern medical practice has led to the present day conflict between patients and health care providers. We must remember however that the doctor-patient relationship involves rights and duties which the patient must bear in mind.

2.2 Rights and Duties of Patients

In addition to granting patients means for the effective redress for negligent injury (which increases the cost of malpractice insurance for physicians—and thus the cost of medical care), malpractice litigation has also promoted what have come to be called patients' rights.[32]

Patients' rights are based upon two fundamental premises:

(1) the patient has certain interests, many of which may be properly described as rights, that are not automatically forfeited by entering into a relationship with a doctor or health-care facility; and

[31] Edward P. Richards, III, JD, MPH, *The Medical and Public Health Law Site*

[32] *Medical Jurisprudence,* Encyclopedia Britannica 2005 – Ultimate Reference Suite CD-Rom

(2) doctors and health-care facilities may fail to recognize the existence of these interests and rights, fail to provide for their protection or assertion, and frequently limit their exercise without recourse.[33]

Perhaps the most important development in patient rights has been that in the United States regarding the doctrine of informed consent. This doctrine requires physicians to share certain information with patients before asking for their consent to treatment. The doctrine is particularly applicable to the use of surgery, drugs, and invasive diagnostic procedures that carry risks. It requires the physician to describe the procedure or treatment recommended and to list its major risks, benefits, alternatives, and likely prospect for recuperation. The purpose is to promote self-determination by patients on the theory that it is the patient who has the most at stake in treatment and who relies largely on the physician for such information. British courts have rejected this formulation on the basis that the average British citizen does not want such information, and British physicians do not generally provide it unless requested.

In 1972 the American Hospital Association adopted a patient bill of rights based on the premise that "[the] traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure . . . the institution itself also has a responsibility to the patient."[34] The text of the American Hospital Association bill of patient rights calls for the rights of the

[33] *Supra note* 3
[34] *Supra note* 3

patient to respectful care, complete medical information, information necessary for informed consent, refusal of treatment, privacy, confidentiality, response to requests for service, information on other institutions involved in the patient's care, refusal of participation in research projects, continuity of care, examination and explanation of financial charges, and knowledge of hospital regulations.

The Parliamentary Assembly[35] submitted a draft recommendation to its member nations suggesting that all necessary action be taken to ensure that the sick can receive relief from their suffering and that patients be adequately prepared for death. They further recommended that commissions be established to study the issue of euthanasia and that physicians acknowledge that the sick have a right to full information, if requested, on their illness and the proposed treatment. The council listed the following basic rights for the humane and dignified treatment of patients: the right to freedom, to personal dignity and integrity, to information, to proper care, and to not suffer.[36]

No one bill of rights is suitable for every health care institution, and specialty hospitals, such as maternity and pediatric hospitals, may require different approaches. Among the basic rights of a patient should be the right to clear communication: accurate information concerning possible medical care and procedures; informed participation in all decisions involving the patient's health-

[35] 1970 – *Council of Europe*
[36] *Supra note* 3

care program; and a clear, concise explanation of all proposed procedures, including possible risks, side effects, and problems related to recuperation.

Patients also should have rights regarding quality of care: a right to an accurate evaluation of their condition and prognosis without treatment; knowledge of the identity and professional status of those providing services; information contained in their medical record; access to consultant specialists; and refusal of treatment.[37]

The patient should have basic human rights: the right to privacy of both person and information; of access to people outside the health-care facility; and to leave the health-care facility regardless of his condition.

The goals of such a system are to protect patients, especially those at a disadvantage within the health-care system (e.g., the young, the illiterate, the uncommunicative, and those without relatives); to make available to those who seek it the opportunity to participate actively with the physician as a partner in a personal health-care program; and to put into proper perspective medical technology and pharmaceutical advances.

Until the 1960s law and medicine met only in the courtroom, and then usually only in cases involving pathology or psychiatry. Since then, however, civil litigation, public financing, and ethical issues have grown, at least partially as a

[37] *Supra note* 3

result of the incredible successes of medicine. These successes have increased public expectations and increased the cost of medicine; they also have made decisions about terminating care more ambiguous. Enhancing patients' rights is one modern concern on which both medical and legal practitioners agree.

Considering the wide variety of medical services, though it is impossible to formulate the rights of all the patients, the following are affirmed patients rights:[38]

1. being informed about what is wrong and how the doctor hopes to help the patient, in a language that he can understand;
2. being provided with competent medical care;
3. not being made to wait for excessively long amounts of time before being attended to;
4. receive from his physician information necessary to give informed consent prior to the start of any procedure of treatment;
5. be treated in private and that the doctor should maintain professional secrecy;
6. receive complete information and explanation concerning the need for an alternative form of treatment or transfer to another facility which must have accepted the patient for transfer;
7. seek a second opinion by consulting another doctor;
8. complain and seek redress.

[38] www.obgyn,net

Thus not withstanding the rights of the patient, regard must be had to the adage that says rights come with responsibilities. In this regard, the following are the *patients' duties and responsibilities:*

1. *keeping appointments punctually;*
2. *taking medicines as prescribed;*
3. keeping review dates and contacting the doctor should symptoms persist;
4. paying promptly for his services.[39]

2.3 Rights and duties of Medical practitioners

When considering the rights and duties of medical men and women, what must be borne in mind is that both action and lack of action can have a detrimental effect and the medical practitioner must be considered accountable on both counts. According to the International Code of Ethics[40] the physician shall have such duties to the sick as:

- always bearing in mind the obligation of preserving human life;
- owing his patient complete loyalty and all the resource of his science – whenever an examination or treatment is beyond the physician's capacity he should consult another physician with the necessary ability;
- preserving absolute confidentiality on all he knows about his patient even after the death of the patient;
- giving emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

[39] The lists of duties and responsibilities of patients is not exhaustive but illustrative
[40] *World Medical Association,* (1949); (1968); (1983)

As regards the rights of physicians, it can be said that they have a spectrum of rights which, among others, include a right to practice within the code of medical ethics and legislation of the country in which they practice. Personal safety, freedom from abuse, threats or intimidations are all rights of medical practitioners.

The doctor-patient relationship is, therefore, important because once formed, the doctor owes a duty to the patient. This relationship is formed when the physician agrees to care for the patient and is a basis upon which an action for medical negligence can be maintained. Generally speaking, a claimant must usually show the following:

- the health care provider owed a duty to the patient;
- the health care provider breached that duty;
- the patient suffered an injury as a result of that breach and;
- the health providers breach was the patient's proximate cause for the injury.

Even if it is established that a duty existed and the health care provider breached that duty, such as failing to meet the requisite standard of care, a claimant may not recover unless he suffered injuries that were a direct result of the breach.

2.4 Relevance of medical negligence in Zambian Legislation

A search through the Zambian legislation reveals that there is not much to talk about in the context of medical negligence. What came to light however, was the following legislation which is relevant to the subject under discussion and included the Constitution, the Medical and allied Professions Act and the Penal Code.

2.4.1 The Constitution of Zambia

In Zambia, the Constitution, CAP 1 of the Laws of Zambia, declares that it is the supreme law of the land. The relevant section provides that; "*this constitution is the supreme law of Zambia and if any law is inconsistent with this Constitution that other law shall, to the extent of the inconsistency be void*".[41]

It has been noted that a physician's duty, among others, is to always bear in mind the obligation of preserving human life. This is consistent with the provisions of Article 12(1) and 12 (2) as cited above. The Constitution however does not expressly or impliedly appreciate the possibility of professional negligence and more specifically, medical negligence. In this regard it must be noted that by its nature, the Constitution cannot provide for every detail that may occur. However, it is a grand norm with which all subservient legislation must comply. In this respect, recourse is had to subservient legislation like the Medical and Allied Professions Act.

[41] Article 1(3) of the Constitution of Zambia

2.4.2 Medical and Allied Professional Act

The Medical and Allied Professional Act provides for the regulation of medical, paramedical, dental and allied professions and for matters connected with or incidental to the foregoing. It is particularly important for making provision for the establishment of the Medical Council of Zambia.[42] The Medical Council of Zambia strives to provide adequate guidance to the medical practitioners so as to uphold the high esteem of the noble professions that deal with health because of all the professions; none require morals more than medicine.[43]

Selekani S. Banda the Assistant Dean of the School of Medicine at the University of Zambia, in his book "**Infamous Conduct**"[44]noted that the Zambian law (through the Medical and Allied Professions Act) has empowered the Medical Council of Zambia to safeguard and protect the interests of the public, as well as moderate the professional and personal conduct of members on its register. A detailed discussion of the Medical Council of Zambia is given later in Chapter 3.

2.4.3 Penal Code

The Penal Code[45] is another example of subservient legislation. A search through the Code reveals that it recognizes culpable negligence and in this regard for instance the Penal Code provides that *" a person is not criminally responsible for performing in good faith and with reasonable care and skill a*

[42] Cap 297 of The Laws of Zambia,
[43] Section 3 *Supra note* 13
[44] (1997) Medical Council of Zambia
[45] Cap 87 of the Laws of Zambia

surgical operation upon any person for his benefit, or upon an unborn child for the preservation of another's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case."[46]

A search through Zambian case records reveals that there has been an attempt by the court to develop some jurisprudence in the context of medical negligence. Thus in the case of ***The People v Zulu,***[47] the Court noted that the case was not one of causing death of a person by doing an unlawful act per se,[48] it was a case of manslaughter by negligence, and it was necessary to consider relevant law. The Penal Code[49] was considered and the material part of section 176 of the Code reads:

"Any person who by an unlawful.....or omission causes the death of another person is guilty of the felony termed manslaughter. An unlawful omission is an omission amounting to culpable negligence to discharge a duty tending to the preservation of life or health....."

The Code, so far as is material, provides as follows:[50]

"It is the duty of every person who, except in a case of necessity, undertakes to.....administer medical treatment to any other person ....to have reasonable skill and reasonable care .....and shall be deemed to have caused

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[46] Section 234 *Supra note* 16
[47] Evans J *Supra note* 26
[48] *Penicillin Ordinance,* Section 3(2) -(Ordinances were laws made directly by the Queen for the Colonies).
[49] 1965, Cap 6 of The Laws of Zambia (as at that time).
[50] Section 190 *supra note* 16

the final consequences which adversely affect the life or health of any person by reason of any omission to observe or perform that duty"

The learned judge observed that the accused, undoubtedly undertook to administer medical treatment (by way of injection) to the deceased. He was therefore under a duty in law to have reasonable skill and reasonable care on administering it. The learned Judge found as a fact that he possessed no skill and used no care, except in the pure mechanics of giving the injection. He has no medical training and no knowledge of the properties or usage of chloroquine or of its 'correct dosage'. Accordingly, he was in breach of the said duty, which is a duty tending to the preservation of life and health. The judge, therefore, held that failure to discharge the said duty amounted to culpable negligence. He observed that the Judges have used many epithets, such as 'culpable; criminal; gross; wicked; clear or complete', in order to determine whether the negligence in a particular case amounted to a crime.

In its present form the Penal Code makes it very difficult to find liability against medical men or women. The submission is consistent with the approach taken by the Court in ***Cicuto v Davidson and Oliver.***[51] In this case the court noted as follows:

".....there is a natural feeling that they (plaintiffs) should be compensated. But we should be doing a disservice to the community at large if we were to impose liabilities on ....doctors, for everything that happens to go wrong. Doctors would

[51] (1968) ZR 149 (HC)

be led to think more of their own safety than the good of their patients. Initiatives would be stifled and confidence shaken....."

The implication is that even if awareness efforts around medical negligence were doubled, people will have little confidence that there is any protection from the vice from the formal structures. Chapter 3, therefore, explores the regulatory framework in Zambia vis-à-vis Medical negligence.

2.5 Medical Negligence and Insurance

It has been submitted that in the particular field of healthcare, there are many contemporary studies, which demonstrate that error is relatively common. As in the ***Cicuto case,***[52] it suggests that redress is comparatively rare, occasionally necessary and sometimes fully justifiable. However it is potentially costly on medical practitioners. In this regard, the phenomenon of insurance could be an alternative. Experience has shown that the provision of schemes of compulsory insurance in fields of employer liability and motor car negligence contributed significantly to the growth of a specialized section of the legal profession with particular expertise much enthusiasm for pushing forward negligence liability generally.[53] It should be no doubt that, in other jurisdictions particularly in Australia, this push came to be felt in the field of medical negligence. There, the practical consideration meant that a profession able to do so would ordinarily be

[52] Magnus J *Supra note* 22

[53] Honourable Justice Michael Kirby AC CMG, *Medical Malpractice – An International Perspective of Tort System Reforms.* Text on which was based on an opening address at the Conference at Royal College of Physicians, London, (2000)

insured, as would the institution in which, and with which, the profession works. According to Lord Hoffman,[54] virtually all compensation is paid directly out of public or insurance funds and through intricate series of economic links. Thus, Zambia would do well to take a leaf from other jurisdictions, with special attention paid to the unique character of each legal jurisdiction. In this regard, Chapter 4 of this essay discusses best practice examples at a regional and international level.

2.6 Ethical Considerations versus Public Interest

Professional ethics are principles that regulate the conduct of relationships between professionals and others with whom they come into contact in the course of their work, primarily their relationship with their patients or clients, but also with their colleagues and other health workers.[55] Traditionally the doctor-patient relationship is regarded as one of trust and dependence on the part of the patient and power and privilege on the part of the physician. Accordingly, observance of the principles of medical ethics by health professionals has always been regarded as particularly important in all circumstances.

Quite obviously, medical negligence claims are potentially injurious on the said patient-doctor relationship. Thus, the allegation of medical negligence is not only potentially costly, it is also personally insulting. It is emotionally hurtful and tends to attract media coverage. It is damaging to one's ego and practice, and defending a medical negligent case is distracting and time consuming. Knowing

[54] *Dimond v Lovell* (2000) 2 WLR 1121 (HL) at 1133
[55] Sekelani Banda, *Medical Ethics and Reproductive Health, supra note* at 61

of the devotion over long hours which the typical health practitioner gives in the highly personal world of care to patients who are living and dying and their families, there is a sense of irritation with the patient who makes a big thing of what may be seen as a trivial, irrelevant or forgivable mistake.

On the other hand, a democratic society is not likely to tolerate a legal system, which denies a remedy to victims of medical negligence at least in serious cases. Such denial would be viewed as sanctioning an unjustifiable assignment of the economic burden of medical error, a failure to afford effective legal stimulus to the careless individual and to provide systematic remedies necessary to prevent such errors from recurring.[56] A detailed analysis of the regulatory environment with regard to medical negligence is covered in Chapter 3.

2.7 Summary

It is necessary to acknowledge that medical negligence in Zambia is a reality and since disinterested benevolence is not a regular feature of social life, people must be encouraged to avoid harming others as they seek their own ends. Thus, when harm is done, it is important that acceptable remedies be applied to undo the harm as much as possible. It is also important to take steps that will reduce the likelihood of harm being done in the future. This requires holding to account those (and only those) who properly are accountable when something untoward occurs. Furthermore, this must be complimented with putting in place appropriate

[56] Justice Michael Kirby AC CMG *supra note* 24

legislation in the context of medical negligence, educating the public and health practitioners on relevant law and on the rights and duties of both patients and physicians generally.

CHAPTER THREE

This chapter will look at the perceived flaws and shortcomings of the Health Act and the role of the Judiciary in the interpretation of the law and combating professional negligence. The chapter will look at the courts from the Supreme Court, to the local courts; the Commission for Investigation and the role of the Medical Council of Zambia and its impact on negligent medical practitioners. The efficacy of the formal structures vis-à-vis medical negligence.

3.0 Introduction

The administration of Justice in Zambia is an important element as is the case in any civilized legal system. Institutions termed as "formal structures" have been put in place and not only are they concerned with the administration of justice, but also form part of the mechanism for the enforcement of the law. The categorization of the institutions adopted herein was created under governmental law for the purpose of adjudication as formal structures.[57] These include the judiciary and the various courts under this broad heading and the Commission for Investigations. The medical council of Zambia is one such institution particularly as it relates to the subject under discussion – medical negligence.

[57] See WLSA, Women and Justice, Myth or Reality in Zambia, p25-27 (1999)

In the words of **Abadee A.;**

'....it is essential for the courts to streamline their processes in medical malpractice cases. Doing so will help promote mediation and court referred alternative dispute resolution where this is appropriate.'[58]

3.1 The Judiciary

The judiciary consists of the Supreme Court, High Court, The Industrial Relations Court, Subordinate Court and the Local Courts.[59] Article 91 of the Constitution of Zambia prescribes that judges, magistrates, members and justices shall be independent , impartial and subject only to the constitution and the law and shall conduct themselves in accordance with a code of conduct promulgated by parliament. The role of the judiciary is to interpret and give effect to the law as passed by parliament. The judiciary is enjoined to uphold the Constitution and therefore any law which is contrary to the constitution, upon the court so declaring, would be regarded as unconstitutional and would therefore be null and void to the extent of the inconsistency. [60]

3.2.1 Local Courts

The Local courts fall at the bottom of the judicial hierarchy and the act governing the administration and jurisdiction of the Local Courts is the Local Courts Act.[61] These courts handle both civil and criminal matters and in terms of the volume of

[58] A. Abadee, "Steamlining the Court Process for Medical Legal Cases – the Professional Negligence list (NSW) and Expert Evidence in (2000) 8 Australian Health Bulletin, 105
[59] The Constitution of Zambia, Article 91(1)
[60] Article 1(3) of the Constitution
[61] Cap 29 of the Laws of Zambia

business, they handle most of the civil cases. The Local Courts handle mostly customary law matters[62] – medical negligence cases are therefore too complex and they lack the acumen to handle such matters as it is beyond their scope. It is very rare that one would commence an action for medical negligence in a Local Court.

3.1.2 Subordinate Courts

The act governing the Subordinate Courts is the Subordinate Courts Act[63] and is supported by other pieces of legislation such as the Criminal Procedure Code and the Penal Code. These courts have both civil and criminal jurisdiction within the limits of the districts in which the courts are constituted. The adjudicators are magistrates who handle the bulk of the civil and criminal matters.[64] Subordinate Courts are courts of first instance and it is important to note that medical negligence cases will commence here therefore making the Subordinate Courts and the magistrates important as regards the enforcement of these cases.

3.1.3 High Court

This court was created by the Constitution of Zambia[65] which confers upon the High Court unlimited and original jurisdiction to hear and determine civil and criminal matters. The only exceptions are labour related matters which are reserved for the Industrial Relations Court. The High Court is important in terms

[62] WLSA Supra note 57 at p37
[63] Cap 28 of the Law of Zambia
[64] AFRONET, Zambia Human Rights Report, (2000) p 62
[65] Article 91

of administration and enforcement of medical negligence in relation to the law and policy and has an opportunity to adjudicate on cases as seen in the case of ***Cicuto v Davidson & Oliver.***[66] The High Court is a superior Court of record which should be noted as an important factor.

3.1.4 Industrial Relations Court

This court is also a creature of the Constitution[67] and in terms of hierarchy is at par with the High Court. Its powers, functions and proceedings are seen in the Industrial Labour Relations Act[68] which confers on the Industrial Relations Court original jurisdiction in all labour related matters. The Industrial Relations Court jurisdiction is limited to labour issues[69] and therefore medical negligence falls outside this scope.

3.1.5 Supreme Court

This is the summit of the judicial hierarchy in Zambia and was created by article 92 of the Constitution of Zambia. The Supreme Court has jurisdiction to hear and determine appeals in civil and criminal matters as provided by the Supreme Court Act. The Supreme Court is strategically placed regarding law reform; whereas Parliament is the supreme law-making organ in Zambia, the role of the judiciary is to interpret and give effect to the law as passed by parliament.[70]

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[66] Supra note
[67] Article 91(1)
[68] Note that the qualifications for its personnel are those of High Court justices (section 86 (2))
[69] Cap 269, Part XI Section 85 (1)
[70] Cap 25 of the Laws of Zambia

3.1.6 Commission for Investigations (OMBUDSMAN)

This is an institution created by the Commission for Investigations Act[71] and comprises of the Investigator General and 3 other Commissioners. It has been set up for the purpose of investigating the maladministration among public officers. The Commission deals with complaints of abuse of power, arbitrary decisions, omissions and improper use of discretionary powers and the like.

The Commission has the mandate to deal with maladministration attributable to office holders of the Medical Council of Zambia, which is amenable to the Commission as is it a statutory body created by an act of parliament.[72] In cases of medical negligence, where the Medical Council of Zambia has been moved by an action against a medical practitioner; it ought to investigate or act on complaints.

3.2 The Medical Council of Zambia

The Medical Council of Zambia is a Statutory Body established in 1965 under CAP 297 of the Laws of Zambia.[73] The Mission of the Council is to set, promote and regulate ethical and professional standards of practice of health care professionals so as to ensure the provision of quality health care services to the public.

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[71] Per Mrs Justice L. Chibesakunda at the ZARAN Judges workshop on HIV/AIDS and Human Rights, (2003), Lusaka

[72] Chanda A.W. Transparency International, Zambia, Study Report (2002) p35

[73] Cap 297 of the Laws of Zambia

3.21 The principal functions of the Council

The Council protects the patient and guides the health professionals to:

- Register all health practitioners so as to allow them to practice in Zambia;
- Regulate professional conduct of health practitioners;
- Register private hospitals, consulting rooms, diagnostic services and other specialized health services so as to allow them to provide health services to the public;
- Monitor quality control and quality assurance in private hospitals, consulting rooms, diagnostic services and other specialized health services; and
- Advise the Minister on matters related to the health profession.

The Medical and Allied Professions Act under which the Council is registered, lays a strong responsibility on the Council to protect, promote, safeguard and maintain the health and safety of the patient or client by ensuring that appropriate standards are put in place in the practice of medicine and health delivery service. Consequently, the council strives to strengthen its statutory role as a regulator by committing itself to the values of the supremacy of the patient and enhancing the reputation of the medical and health profession.

The task of the Council therefore evolves on building on the strengths and achievements of the medical profession and in this regard, the Council has upheld the principle and will continue to uphold the principle of:

- Ensuring high standards of professional practice among all registered health practitioners;
- Need for sound professional and educational background as a basis for good practice in medicine and other health related disciplines;
- Dealing firmly, fairly and timely with health practitioners who fail to maintain ethical or professional standards or whose fitness to practice is questioned;
- Providing an effective and efficient supervisory role to the practice of medicine and other health professions so as to maintain a high reputation in professional ethics;
- Providing an effective monitoring framework for health care in institutions registered and controlled by the council; and
- Effectively running and administering the systems for registration and licensing of medical and other health practitioners registered under the Council.

3.2.2 Registration of Practitioners

The registration of health practitioners who meet the standards of professional competence, care and ethical conduct, is one of the major activities of the Council.

The registration and renewal of practicing certificates for both local and foreign practitioners is strictly done on the basis of the standards, rules and procedures governing registration of health professionals who are subjected to strict scrutiny

and screening before registration so as to ensure that patients receive quality health care in a conducive environment.

3.2.3 Professional and Ethical Conduct

All health practitioners registered under the Council are expected to adhere to a professional and ethical code of conduct as prescribed in the Rules issued under the Medical and Allied Professions Act, CAP 297 of the Laws of Zambia. In addition to this, all practitioners registered with the Council are expected to observe principles of good medical practice which are:

- To make the care of the patient the practitioner's first concern;
- To treat every patient politely and considerately;
- To respect patients dignity and privacy;
- To listen to patients and respect their views;
- To give patients information in a way they can understand;
- To respect the rights of patients to be fully involved in decisions about their care;
- To keep his/her professional competence;
- To be honest and trustworthy;
- To respect and protect confidential information;
- To make sure that his/her personal beliefs do not prejudice his/her patients care;
- To act quickly to protect patients from risk if he/she has good reason to believe that he/she or a colleague may not be fit to practice;

- To avoid abusing his/her position as a practitioner; and
- To work with colleagues in the ways that best serves patients' interest.

The Medical Council has statutory powers to regulate the professional and ethical conduct of Practitioners registered under the Act. These powers are exercised through the Displinary Committee, and were conferred on the Council by the Medical and Allied Profession Act 1977.

The Council's jurisdiction in relation to professional misconduct and criminal offences is now regulated by section 55(1) of the Medical and Allied Professions Act 1977 and the Displinary Proceedings (Rules) 1982. The jurisdiction over a practitioner's conduct is applied where there is a written complaint to the Council that a Practitioner has committed or is alleged to have committed an infamous conduct in a professional respect.

The phrase "infamous conduct in a professional respect" was defined by **Lord Justice Lopes**[74] as follows:-

> ***"If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonorable by his professional brethren of good repute and competency, then it is open to the General Medical Council if that be shown, to say that he has been guilty of infamous conduct in a professional respect."***

[74] 1894, *United Kingdom*

In another judgment delivered by **Lord Scrutton** stated that:-

> ***"Infamous conduct in a professional respect means no more than serious misconduct judged according to the rules, written or unwritten, governing the profession."***[75]

The Medical Council of Zambia intended that the phrases should have the same significance in Zambia. Where the practitioner is found guilty, the Council imposes one of the following penalties:

- Censure;
- Caution;
- Ordered to pay costs; or
- Erasure f the practitioner from the Register.

Any party to the proceedings aggrieved by the Council's decision may appeal to the High Court within 90 days of the Council's ruling.

In the area of monitoring professional and ethical discipline, last year, the Council had 19 disciplinary cases (of which two were medical negligence cases) involving health practitioners. 10 of these cases were concluded and disposed of while 9 were adjourned to this year, 2006. Of the 10 cases that were disposed of, 8 practitioners were found guilty; 6 of which were made to pay costs whereas 1 was severely censured while the other was cautioned. **Table 1**[76]

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[75] 1930

[76] Medical Council of Zambia, Annual Report (2005)

The number of general public complaints against Practitioners reported to the Council increased to 10 as compared to 4 in 2004. This increase is significant in that the public or people are becoming more and more aware of access to quality health care as guaranteed in the Council's Mission Statement and the National Health Policy.

3.2.4 Convictions and forms of Professional Misconduct which may Lead to Disciplinary proceedings

Reference is made to certain kinds of professional misconduct and of criminal offences which have led to infamous conduct in a professional respect. From time to time, with changing circumstances, the Council's attention is drawn to new forms of professional misconduct.

The areas of professional conduct and personal behavior have been grouped under four main headings, namely;

1. Neglect or disregard by practitioners of their professional responsibilities to patients for their care and treatment;
2. Abuse of professional privileges or skills
3. Personal behavior, conduct derogatory to the reputation of the medical profession;
4. Advertising, canvassing and related professional offences.[77]

These headings have been adopted for convenience, but such classifications can only be approximate – the one this essay is concerned with is the first one which we will look at in more detail.

[77] Passmore R & Robson J (1974). A Companion to Medical Studies, ethical and legal aspects of medicine chapter. Blackwell Scientific Publications, Oxford

3.3 Neglect or Disregard of Personal Responsibilities to Patients for their care and treatment

3.3.1(1) Responsibility for Standards of Medical Care

The Council in pursuance of its primary duty to protect the public institutes disciplinary proceedings when a medical practitioner, dental surgeon, pharmacist or a paramedical registered with the Medical Council of Zambia appears to have disregarded or neglected his professional duties to his patients, for example by failing to visit or provide or arrange treatment for a patient when necessary.

The public are entitled to expect that a registered practitioner will afford and maintain a good standard of medical care. This includes:

- Conscientious assessment of the history, symptoms and signs of a patient's condition;
- Sufficiently thorough professional attention, examination and, where necessary, diagnostic investigation;
- Competent and considerate professional management;
- Appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention; and
- Readiness, where the circumstances so warrant, to consult appropriate professional colleagues.

A comparable standard of practice is to be expected from practitioners whose contribution to a patient's care is indirect, for example those in laboratory and radiological specialties.

The Council is concerned with errors in diagnosis or treatment, and with the kind of matters which gives rise to action in the civil courts for negligence, only when the practitioner's conduct in the case has involved such a disregard of his professional responsibility to patients or such a neglect of his professional duties as to raise a question of infamous conduct in a professional respect may also arise from a complaint or information about the conduct of a practitioner which suggests that he has endangered the welfare of patients by persisting in unsupervised practice of a branch of medicine which he does not have the appropriate knowledge and skill and has not acquired the experience which is necessary.

3.3.1(2) improper delegation of Medical Duties

The Council recognizes and welcomes the growing contribution made to health care by Clinical Officers, Pharmacy Technician, Nurse Aids and other persons who have been trained to perform duties at specific levels. It has no desire either to restrain the delegation to such persons or treatment or procedures falling within the proper scope of their skills or to hamper the training of medical and other health students. But a Medical practitioner, dental surgeon or pharmacist who delegates treatment or other procedures must be satisfied that the person to whom they are delegating is competent to carry them out. It is also important that the practitioner should retain ultimate responsibility for the management of his patients because only the practitioner has received the necessary training to undertake this responsibility. For this reason a practitioner should not delegate

his duties to an unqualified person if such duties require the practitioner's personal knowledge and skills.

3.4 Summary

Efficacy of Formal Structures vis-à-vis Medical Negligence

The fact that there has been very little litigation involving medical negligence in Zambia can be attributed to the following factors;

- The gap between the law and society as alluded to in Chapter 2. The Zambian society lacks the awareness of the rights and duties of both the patient and the medical practitioner;
- The justice delivery system which is further complicated by procedure;
- Poor infrastructure of the judicial system;
- High cost and the lack of access to legal representation;

The fact that most medical negligence cases are conducted under public hearing is a deterring factor and discourages medical practitioners from coming forward to give evidence as this could be damaging to their profession. There is a need to encourage other forms of resolution like Alternative Dispute Resolution which ensures privacy and confidentiality. It has been suggested that the approach taken so far by the 'formal structure' protects medical practitioners and does not therefore inspire confidence in the public. There is a need to revisit these structures, give them a complete overhaul so as to position them for equitable, efficient and effective justice delivery.

CHAPTER FOUR

4.0 INTRODUCTION

In this chapter focus will be on recommendations for the improvement in the service delivery of health facilities and moral adjustments of the people involved in the medical profession. Included in this chapter will be a brief background, compensation for negligence, no fault legislation, capping damages, government intervention and who acts as the in-house ombudsman. A look at risk management and how it is applied will be discussed and how best to ensure the duty and standard of care owed to patients and Zambians in general is administered and that the negligent medical staff bear the brunt of their mistakes. Therefore possible suggestions for law reform and the conclusion to the study will be offered with the focus being on remedial actions generally, taking into account the international perspective as well as the local Zambian one.

4.1 Relationship of law and ethics

The legal philosopher, **Lon Fuller,** has distinguished between "the morality of aspiration" and "the morality of duty."[78] The former may be denoted ethics, the latter law. Ethics tells people what they should do and embodies the ideals they should strive to attain. Unethical behavior leads to punishments that are related to how an individual is perceived, both by himself and by his fellow man. Law, on the other hand, provides boundaries of actions, set by society, beyond which a

[78] Fuller, *The Morality of Law,* 46 (1964)

person may go only by risking external sanctions, such as incarceration or loss of a medical license.

This may explain why ethical codes usually involve generalities, while laws tend to be more specific. For example, the ***Hippocratic Oath***,[79] formulated in the 5th century BC, is concerned with the physician's doing no harm, refraining from performing abortions and giving deadly drugs, and maintaining strict confidentiality. Law, on the other hand, may permit abortions under certain circumstances, permit the giving of potentially lethal drugs in extreme situations, and sanction the violation of confidentiality when the interests of society demand it.

Although the Hippocratic Oath has largely been superseded by such modern oaths as the Declaration of Geneva, the International Code of Medical Ethics, and the Canons of the American Medical Association, these codes of conduct retain the brevity and generality of the Hippocratic Oath. For example, the International Code of Medical Ethics developed and promulgated by the World Medical Association shortly after World War II, provides in part for the following:

- A doctor must always maintain the highest standards of professional conduct;
- A doctor must practice his profession uninfluenced by motives of profit. . . ;
- A doctor must always bear in mind the obligation of preserving human life;
- A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.

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[79] Sekelani Banda, *A Handbook of Medical Ethics for Medical Students and Health Professionals* (1998) Zambia Medical Association p.iv

In the landmark case of **Karen Ann Quinlan.**[80] Her parents requested her physicians to remove the mechanical respirator in order to let their daughter die a natural death. The doctors refused, relying primarily on medical ethics, which they believed prohibited taking an action that might lead to the death of the patient. In court, however, the lawyers for the Quinlan family argued that what was at stake was not medical ethics but the legal rights of the individual patient to refuse medical treatment that was highly invasive and offered no chance for a cure. The court agreed that patients have the legal right to refuse medical treatment, determined that honoring such a refusal was consistent with medical ethics, and decided that the parents of Karen Ann Quinlan could exercise her right to refuse treatment on her behalf. The case of Karen Ann Quinlan has become a parable of modern medicine and of the relationship between medical ethics and the law. Although an issue was made of medical ethics by both the physicians and the court, the case primarily involved medical practice and the fear of potential legal liability.

The Massachusetts Supreme Court, for example, has summarized the criminal law in this regard:

> ***"Little need be said about criminal liability: there is precious little precedent, and what there is suggests that the doctor will be protected if he acts on a good faith judgment that is not grievously unreasonable by medical standards."***

[80] (1976) New Jersey Supreme Court, USA

4.2 Legal redress

When patients are injured by medical negligence the remedies they can pursue depend upon the country's legal system. In the United States, for example, lawsuits against physicians for negligent injury are not considered unusual. Malpractice, or professional negligence, is the failure of a health-care provider (for example, a physician, dentist, nurse, or pharmacist) to exercise the ordinary care and skill a reasonably prudent, qualified person would exercise under the same or similar circumstances. The practitioner does not guarantee the outcome but must use diligence and ordinary skill in the treatment of a patient.

A valid malpractice claim must have four elements: duty, breach, damages, and causation. The practitioner must be shown to have a relationship to the patient (which establishes a duty to exercise ordinary care); must have breached that duty (as measured by the applicable standard of care); and through the breach must have caused the patient physical and monetary damages.

The central concern for physicians is usually to establish the standard of care through expert testimony, which may simply be the testimony of another qualified physician. Such testimony is necessary because the standard of medical practice is not something a lay jury is familiar with. Expert witnesses may themselves rely on the standards that have been set down by one or more of the medical speciality organizations, such as the American College of Obstetricians and Gynecologists. These medical speciality organizations provide certification to

physicians who have fulfilled postgraduate training and practice requirements in the speciality. They maintain the standards necessary to practice in the specialties, and they provide reasonable assurance to patients that these standards will be upheld. Nonconformance with such standards by a specialist is evidence of negligence; although it is not conclusively negligence (the practitioner may have a valid excuse for not following custom, such as an emergency situation or lack of equipment). Conformance with the standards is evidence of due care, but it is not conclusive because other factors may have caused the physician's action to be imprudent under the circumstances.

If a practitioner consistently performs below the profession's standard of care (i.e., the practitioner is a negligent physician who does not actually harm anyone) the remedy is not a malpractice action but a complaint to the licensing or registration authority to have the individual disciplined.

4.3 An International Perspective

Medical malpractice actions have three basic functions:

- emotional vindication;
- quality control; and
- compensation for harm.

All of which are achieved to varying degrees. Quality control is probably best achieved, since the standard of care is set by physicians themselves and enforced by patients and juries. Compensation for harm, on the other hand, is

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skewed toward major injuries. Attorneys in the United States, for example, represent malpractice cases on a contingency fee basis—i.e., they are paid a proportion (usually 20–40 percent) of the total amount awarded to the plaintiff. Patients who suffer less severe injuries may have little redress for compensation. In countries that have a system of national health insurance, compensation for harm may not be a major issue (since all medical bills are paid regardless of cause). And countries with comprehensive social services for all citizens, like Sweden and New Zealand,[81] have effectively developed "no fault" compensation systems. But in the United States, where more than 35,000,000 people do not have any form of health-care insurance, lack of coverage can transform a medically induced injury into a financial catastrophe.

Approximately 80,000 people die in the United States each year due to medical malpractice.[82] These statistics have since been confirmed by other studies performed in California and New Jersey. Numerically, this is more than three fully loaded jumbo jets crashing every week with no survivors. That number of airplane crashes would mobilize many commissions, and international investigations and a huge effort to prevent the crashes. Unfortunately, since medical malpractice injuries happen separately and privately, the effect is not the same.

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[81] Compensation for Personal Injury in New Zealand (1967)
[82] Study entitled "Patients, Doctors, Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York," *Harvard Medical Practice study* (1990)

To be emotionally vindicated the patient must be able to make a complaint and be able to get a satisfactory response. A comparison in consumer complaints between the United States and Britain shows significant differences. In 1981 an estimated 700 writs for medical malpractice were issued in Britain. In 1983 about 42,000 claims were filed in the United States. These figures yield a per capita difference (even when the difference in years and between claims and writs is considered) that shows that Americans file claims against physicians more than 10 times as often as their British counterparts. The law professor **Frances Miller** has noted that many cultural and practical reasons serve to explain this difference, including different legal systems and rules, access to attorneys and courts, the method of paying for medical expenses, the special status of the National Health Service in Britain, and the existence of alternative complaint procedures.[83]

The Medical Claims Conciliation Panel is part of the Department of Commerce and Consumer Affairs, State of Hawaii. The law requires that most medical malpractice claims in Hawaii first go through the MCCP process. Basically this involves non-binding arbitration, where three persons act as judges and listen to evidence about a claim and make a decision.[84]

The problem of medical negligence is not only confined to developed countries, the South African jurisdiction has had occasion to deal with the issue of medical

[83] Discussed J Vennell, "Medical Misfortune in a No-fault Society", Mimeo 1989 noted Fleming in The Law of Torts, (9th Edition) 1998 at 451
[84] www.consumerlaw.com/medical.html

negligence. A classic illustration is provided in the case of ***Leonidas Souzou Michael and Thelma Michael v. Linksfeild Park Clinic (PTY) Limited and Dr Hugh M Thomas.***[85] In this case medical negligence was alleged against the defendants. The court observed that although it has often been said in South African cases that the governing test for professional negligence is the standard of conduct of the reasonable practitioner in the particular professional field. In this regard the court alluded to the decision of the House of Lords in the medical negligence case of ***Bilitho v. City and Hackney Health Authority.***[86] The relevant dicta in the speech of Lord Browne-Wilkinson, summarized, were as follows; the court is not bound to absolve a defendant from liability for alleged negligent medical treatment or diagnosis just because of the evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue is in accordance with sound medical practice. However, it will seldom be right to conclude that views genuinely held by a competent expert are unreasonable.

4.4 Remedial Actions

Sometimes remedies to particular problems concerning malpractice suits can be afforded without an actual change in tort law. Thus, in New South Wales, Australia, in 1998 the specific concerns affecting obstetricians and gynecologists facing threats to their practices led to government intervention. The State Treasury Managed Fund agreed to offer to cover for services for public patients.

[85] Case No. 361/98 Supreme Court of South Africa
[86] (1998) AC 232 (H.L.(E)).

Although legal liability law remained the same, some of the risk was shifted to government rather than to patients and their families.

The Parliament of New Zealand adopted the most radical solution following the Woodhouse Report.[87] It abolished tort recovery by statute and replaced it by a comprehensive system of exclusive monetary compensation benefits dependent upon compulsory insurance paid by employers. A decision was originally taken that medical misadventure should be excluded from the Act;[88] however, some cases of medical error are now covered.

It seems unlikely in the short term that comprehensive national compensation will replace the tort system. There is no reason in principle why a statutory scheme could not be adopted in respect of medical negligence. The moves in New Zealand were designed to ensure that healthcare providers contributed to the accident compensation fund and suggests that in democracies, the lawmakers would be resistant to providing special immunities.[89]

The introduction by legislation of semi-arbitrary limits, or 'caps', on the recovery of damages has been a feature in lawmaking in many countries. In Australia, for example, the statutory 'cap' on the recovery of non-financial heads of damages have been introduced in legislation. Effectively, the 'caps' shift a proportion, or the whole, of former legal entitlements to compensation to the person claiming to

[87] Supra note p38
[88] Supra note 2 p 38
[89] Phillips K, "Tort Law Reform" unpublished address to a seminar, Sydney (2000)

be the victim of a legal wrong. In some jurisdictions of the United States, like California, the capping of damages, have had a significant effect on medical malpractice suits. The premium for liability insurance for obstetricians in California in 2004 was said to be USD 40,000 whereas in Florida, a state where no such reforms were enacted, the premiums were said to be USD 152,000 per year.[90]

4.4.1 Risk Management

The introduction of paying closer attention to risk management both by healthcare professional and their insurers is another remedy. A systematic problem in the law of tort recovery is that, court decisions often resolve individual cases but do not necessarily have an impact on matters of practice and of preventing the recurrence of the error. Drawing inferences from particular cases for risk management is an important obligation of modern professionals, their insurers and professional organizations. A report in ***Annals of Internal Medicine***[91] in December 1999 concerned a study of malpractice cases. The authors of the study in answer to the question 'why patients sue', recommended immediate disclosure of errors to patients and a thorough discussion with them about the results and the steps taken to prevent recurrence of error.[92] Whilst lawyers and insurers might hesitate with regard to this advice, the authors of this study at Johns Hopkins University, School of Medicine suggested that such

[90] Fleming Ibid
[91] A.W. Wu, Handling Hospital Errors: is Disclosure the Best Defence? (1999) 131, p970
[92] A.W. Wu Ibid

candour, and if an apology is given appropriately, could diminish the risk of litigation.

4.5 Summary

The current system of tort remedies for medical malpractice makes it clear that what is in place now is often very stressful, uncertain, very expensive and a real ordeal for the average person. A reflection on these harsh realities should propel us to look at other more approachable, cheaper and conciliatory in-house remedies for complaints of medical malpractice. In the Netherlands, every hospital and public healthcare system has established procedures that are easily accessible to patients.[93] This has greatly reduced the number of litigation in medical malpractice cases to a mere fraction of what other countries in Europe experience. The courts could look at streamlining their processes in order to speed up medical malpractice cases, in this way they would facilitate the reception of reliable expert evidence and more easily differentiate reliable testimony from the unreliable.

[93] J Hubben, "Costs of Clinic Negligence in Germany, France, Belgium and in the Netherlands, in Particular – unpublished paper in Physician Insurer's Association of America, Conference Papers, London (2000)

CHAPTER FIVE

Research Findings, Recommendations and Conclusion

5.0 Introduction

There is need for a complete overhaul of the Health system dealing with Medical malpractice in Zambia. The current system is fashioned to deal with the aftermath and not to protect patients from neglect in the first place. Inadequate legal provisions for medical malpractice exist, for example, the law does not provide for laid down procedures and penalties against health care providers who neglect their patients.

5.1 Research Findings

The research that was conducted at various institutions revealed the following:-

5.1.1 Findings at the University Teaching Hospital

-The University Teaching Hospital experiences numerous problems which contribute to the high death toll, including medical malpractice. Another notable problem is overcrowding because of the lack of alternative government hospitals in Lusaka. This has led to low nursing and medical standards at the University Teaching Hospital. [94]

-Accident victims die prematurely or have lasting impairments because of the lack of care of hospital medical staff. Unfortunately due to the inadequate medical personnel most government hospitals are unable to

[94] Source: Ministry of Health

cope with the large numbers of patients who cannot afford private hospital fees and are therefore forced to attend clinics at these institutions.

-Poor working conditions have led to a massive brain drain in the medical profession in Zambia, the government funded hospitals, because of their poor working conditions offered to their staff have been the worst hit. There are occasions when one doctor or nurse will man an entire ward per shift – this makes it practically impossible to give each patient the time and dedication required to nurse him back to health

-An acute shortage of medication and equipment such as blood vials, disposable needles, gloves and sterile gowns makes it very difficult to prevent contamination amongst patients

-The University of Zambia School of Medical School is situated at the UTH and the hospital is used as a training ground for the Residents. These junior student doctors who lack experience are forced to deal with complex situations and patients with no supervision due to the staffing problems

-The result has been numerous deaths, most of them either premature or could have been prevented had there been adequate staff, medicine and less congestion – because one doctor has to deal with a huge number of patients each day, he tends to be neglectful in his diagnosis and treatment of his patients.

5.1.2 Findings at Private Medical Centers and Clinics

- The health system in Zambia has become a major source of income for private hospitals and clinics – the focus has changed from providing a service into a profit making industry. Even before anyone attends to a patient whether in an emergency or not, the demand is for consultation fees

-Patients have been forced to have themselves discharged prematurely due to the high cost of hospitalization, medical consultation and drugs

-patients are diagnosed with a large number of medicines, some unnecessary in order to make a profit.

5.1.3 Views by Patients who have experienced Medical negligence have been much along the same lines;

- the public institutions are overcrowded and patients are forced to wait in queues for long hours before seeing a doctor – some patients die in these queues.

- when one does get to see the Doctor, he is hurried and does not pay much attention to the patient as he has too many patients to attend to and makes mistakes in diagnosis which sometimes proves to be fatal

- on being given a prescription, the medicines are unavailable as the hospital pharmacy hardly has anything in stock

- when referred to the treatment rooms, the nurses and technicians, dish out the same hurried treatment due to the large numbers of patients they

have to attend to, they therefore portray a very uncaring attitude further reducing the patients' confidence. The staff have no gloves to work with and in this day of a high prevalence of the HIV/AIDS pandemic, makes this very risky. A patient is forced to buy his own disposable needles and vials for taking blood samples for testing – the financially challenged are then put at a disadvantage and sometimes leave without receiving adequate medical care.

5.1.4 Findings at the Medical Council of Zambia

- The Registrar was very reluctant to give information even though specific mention was made that it was for research purposes only – this gives a clear indication that the institution protects the health care providers by keeping from the public information that would be beneficial in bringing medical malpractice culprits to book

- The Council has a little handbook giving the guidelines on professional conduct and discipline, and what is required for fitness to practice for health care providers. Very little is said with regard to medical malpractice. Part II (1) (a) provides:

> "The Council in pursuance of its primary duty to protect the public institutes disciplinary proceedings when a medical practitioner, dental surgeon, pharmacist or a paramedical registered with the Medical Council of Zambia appears to have disregarded or neglected his professional duties to his patients, for example by

failing to visit or provide or arrange treatment for a patient when necessary"[95]

-in the year of 2005, out of 19 complaints reported, there was only one conviction in the case of medical negligence[96]

- the Council is understaffed and therefore makes it impossible for them to conduct inspections on new applications and existing ones to ensure standards are met and being maintained; that the health care providers are adequately trained and qualified to perform the functions they are performing and to make timely follow ups on reports made on medical institutions and personnel. There was a Dental Technician who practiced as a Dentist for over 5 years in Kitwe before he was discovered and had by them committed numerous malpractices on patients who had no idea of the reporting channel

-the staff of the Council are not qualified Medical personnel but civil servants dealing with the administration aspect of the profession which makes it very difficult for them to have a hands on impact.

5.2 Interpretation of Results

An analysis of the research findings reveals that there is no clearly established procedure on how to adequately deal with the problem of medical malpractice and that the system itself is mainly to blame for some of the inadequacies of the health system in Zambia. In the absence of such procedure,

[95] The Medical Council of Zambia, *Professional Conduct and Discipline: Fitness to Practice*
[96] Appendix I , Medical Council of Zambia, *Annual Report* (2005)

medical malpractice will continue unabated and patients will continue to die prematurely, be exposed to unwarranted risks and no sign of protection by the Government. This is contrary to the role of the health care providers whose primary concern is to preserve life. The attitudes exhibited from the various institutions visited by the researcher are a clear demonstration of the fact that patients right to health are being violated and not considered as paramount.

> Access to treatment is one of the issues that are at the top of the health agenda in Zambia, however, the difficulty people with health problems face in gaining access to treatment and good health facilities has raised questions regarding the realization of the right to health in Zambia.

The medical staff's attitudes are impacting negatively on the right to life and health of the people, therefore what should be done to help such people? Are there any reasons why minimum state intervention should in certain cases override the age old concept of victimization? These and many other questions will be addressed in this essay, as evidence reveals that cases of negligence are common, and yet there has not been much litigation.

(a) The proposed study and research will after the critical evaluation make suggestions for law reform or revision and make recommendations that will make the Act more effective in the administration and service delivery of health facilities in Zambia.

The health system in Zambia has become a major source of income for both private and public institutions – the focus has changed from providing a service into a profit making industry. Access to treatment is one of the issues that are at the top of the health agenda in Zambia, however, the difficulty people with health problems face in gaining access to treatment and good health facilities has raised questions regarding the realization of the right to health in Zambia.

5.3 Economic Problems

The shortage of medical equipment is a major problem; the hospital lacks a steamer for sterilizing surgical equipment and linen used during operational procedures.[97]

The hospital is so badly funded that there are no finances to supply the admitted patient's meals, the family of the patient is responsible for the nutrition of the patient while in hospital. A weak and inefficient administration had lead to anarchy in medical care. Drug thefts are rampant and employees are constantly being arrested and convicted for pilfering property.[98] A lot of other drugs imported for use in the government hospitals have found their way into the storerooms of private practitioners, sold to them in order to subsidize the medical staff's meager earnings. The lack of modern equipment in these hospitals is illustrated by a case which occurred at Ndola Central Hospital.[99] Siamese twins died shortly after birth because the x-ray equipment used was unable to detect that the twins shared one liver. This loss of lives could have been avoided had the hospital used modern equipment. Persons needing a Kidney dialysis machine or

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[97]

[98] Zambia Daily Mail , (2004) p5

[99] Source: Ministry of Health Administration

chemotherapy for cancerous patients have to travel outside the country to access this equipment as there are non available in Zambia. Another case in point was of a young child who was treated for many months as having quinine resistant malaria – when the parents, out of desperation took him to South Africa for a second opinion, found that the child was actually suffering from Asthma.
A major reason for the brain-drain of medical personnel had been due to poor working conditions, like inadequate accommodation and low salaries.

5.4 Delegation of Duties to unqualified Staff

Duties are delegated to staff not competent in that particular field of work. It has been universally found that medical assistants and general staff attend to serious cases even to the extent of giving injections to patients.[100] A doctor may prescribe the correct dosage and substance to the attendant nurse, but it is his responsibility to check that the correct strength and substance has been administered. Hospital authorities should assume full responsibility for any mishap performed by their servants.

In Zambia cases of medical negligence are referred to the MCZ while others go to the Ministry of Health which is the governing body. The majority of patients who have had the chance of instituting court proceedings prefer to settle out of court.
A striking case which is unreported occurred at the UTH. This was the case in which a 68 year old man died after being given a pint of blood marked "Mambeni"

[100] Knight B., Legal Aspects of Medical Practice (Churchhill Livingstone Press, 1972) p40

(A. Rh positive) which had been requested by a doctor in error. The victim was a O Rh positive and the error was only realized when the second pint, labeled correctly was brought to the ward to continue with the transfusion. The patient died the following day after jaundice and haematuria had become established. The doctor admitted confusing the names of the patient with "Mambeni" who was in the adjacent bed when the blood was requested for. The doctor was found negligent in performing his duties and the court awarded damages to the relatives of the victim.[101] In the case of **PAUL LUBASI V PATEL**[102], the plaintiff was awarded K1,000.00(one thousand kwacha) for negligence by a medical practitioner who failed to detect a piece of glass stuck in the plaintiffs thigh. The defendant simply cleaned the wound, stitched it and prescribed some antibiotics. The wound soon became septic and eventually the whole leg had to be amputated. In a similar case in the UK, the courts awarded GBP 3000.00(Three thousand pounds) to the parents of a child whose leg was amputated due to negligence of a medical practitioner.[103] The marked difference as regards the quantum in the UK courts shows more seriousness and is seen to uphold the idea that professional negligence should be discouraged.

Carelessness in hospital notes and failure to check such notes against the patient in the operating theatre are common. In **KUCHINSKY V MCMAHON**,[104] the court stated: "a physician who neither conducts a pre-operation examination just prior to surgery, nor checks his records to refresh his recollection of the

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[101] (1972) unreported; Source Medical Council of Zambia

[102] (1973) Mongu Hospital and eventually UTH; unreported source Medical Council of Zambia

[103]

[104] (1960) 1 WLR 300; see also Emmanuel H and Jonathan H, Legal Aspects of Medical Records, (Berwyn, Illinois, 1964) p320

operation to be performed and consequently undertakes surgery on the opposite side of body than has been intended is negligent."

It must be appreciated that many forms of treatment hold inherent risks and the courts will not hold liable medical practitioners for every act done which results in unwanted results. The inherent risks do not provide grounds for negligence unless the doctor failed to draw the attention of the patient to these potential risks.

5.5 Recommendations

5.5.1. Public hospitals - should be privatized and the government should be the majority shareholder in order to ensure laid down standards are maintained. This would make the doctors answerable to the organization directly and if they commit acts of malpractice and are found guilty, they can be dismissed and more competent medical staff employed. This would in turn improve the standards of service and lessen eh incidences of medical malpractice. With improved working conditions, better salaries and allowances, better accommodation, the government hospitals will encourage the employment of better qualified and experienced medical practitioners. Better incentives to lure back medical personnel should put a lid on the brain-drain being experienced. This is already evident as to the report published that 15 doctors have returned home from UK, Botswana, Namibia and South Africa. On-call allowances have been increased

from K1.5 million to K2.7million, consultants fees have been raised to K3million per month and a car loan scheme has been put in place for the medical staff.[105]

5.5.2. Illiteracy - is a major contributing factor to the low standards in the health sector; patients are unable to communicate with their doctors due to language barriers. This leads to either the wrong diagnosis being given by the doctor or the patient following the wrong dosage instructions on prescribed medication. In countries like Japan and Germany, expatriates have to learn an indigenous language before being registered as a professional. For example some of the Chinese doctors currently in Zambia cannot communicate with many of their patients. The issue is to make the Zambian people understand the rights of the patient and in the case of negligence on the part of the medical staff, how does one tackle this problem and what measures should be taken for compensation.

5.5.3. More health workshops - should be organized in order to educate the Zambian patient on his rights and duties. There is need to build more government hospitals to avoid the overcrowding currently being experienced at UTH, Ndola Central Hospital and Kitwe Central Hospital to name a few. Public awareness campaigns should be held in order to increase production of informational and educational material on the general law of medical negligence. This should be done using layman's language and translated into the 5 major

[105] Post Newspaper. Thursday January, 4th, 2007 p5

Zambian languages. The creation of a Patients Rights Charter [106]should be developed and made available for public consumption. The MCZ should collaborate with the government departments and Non-governmental Organizations to form strategic partnerships. Distribution of these materials can be done through schools, health centers and participating outlets like Shoprite for example.

5.5.4. Alternative Dispute Resolution - should be encouraged and this is one area that the Law Association of Zambia can play its part. Because of the low costs of ADR, privacy, confidentiality, speedy resolution and guaranteed party autonomy, it would be a popular avenue for those opposed to going to court because of the long and drawn out procedure. ADR encourages relationships to continue due to amicable resolution.[107]

5.5.5. Training - The UNZA medical school should increase the intake of medical students in order to meet the demand

5.5.6. Medical Council of Zambia - should be given more statutory powers, it should become autonomous and the power of registration of medical practitioners should be wholly vested in the Council in order for it to be more effective and be run more efficiently. The MCZ, should also tighten their reins

[106] e.g. Churches Health Assiciation of Zambia (CHAZ) and Zambia AIDSLaw Research and Advocacy Network (ZARAN)
[107] Young A.P. Alternative Dispute Resolution and its Place in the Zambian Judicial System, 32 Zambia Law Journal (2000), p79-84

and scrutinize applications for licenses and practicing certificates in order to weed out unqualified staff and bogus practitioners. The MCZ could issue statutory instruments tailored in such a way that it will help make health care providers accountable.

5.5.7. An in-house ombudsman - should be created as this will encourage procedures that are easily accessible and patient friendly. These should be established throughout the hospitals, clinics and health centers; it should be an essential feature of every health facility and could be ensured through law and policy.

5.5.8. Compulsory Insurance policies - for Medical practitioners or institutions against liability could be introduced as has been done in other countries
The School of Law could incorporate medical negligence it its curriculum as this is an issue of great public concern and will allow lawyers to play their rightful role in society.

5.5.9. Risk management – the duty of the medical practitioners to disclose errors to patients and adopt a culture of discussing tests and steps taken or about to be taken, results of procedures in order to prevent recurring error.

5.6 CONCLUSIONS

-Misunderstandings surround medical negligence among the medical profession. An action is considered as a personal attack on the medical profession by the legal profession.

-Breach of a right guaranteed by the Constitution is considered to be a civil wrong and a violation of a fundamental human right. Medical negligence is by its very nature a civil wrong and entitles the victim to redress at law. The approach taken by the courts in dealing with medical negligence cases runs towards giving medical practitioners immunity. This has robbed the public of confidence in the national court system and has resulted in lack of litigation around medical negligence related issues, leading to increased settlements out of court. This leads to culprits going Scot-free and because they are not exposed publicly, they continue to cause deaths and irreparable harm to patients.

-The gap between relevant law and society has lead to a general lack of appreciation for the law relating to medical negligence and to a breakdown in the physician-patient relationship.

-The MCZ is clustered with impediments such as lengthy procedures, prohibitive costs, geographical location i.e. centrally located, lack of guarantee regarding confidentiality and the lack of appreciation of the role of the law among the personnel.

5.7 SUMMARY

Medical negligence is a bigger problem than most people want to admit. It is apparent that a legal system that denies a remedy to victims of medical negligence is not likely to be tolerated in a democratic society. The question arises as to what can be done to respond effectively to the complaints about the current law of civil remedies in a way that attempts to meet the concerns of the reasonable critics whilst affording relief to those who suffer because of mistakes that could be avoided in the provision of proper healthcare. In Zambia it seems no one acknowledges the fact that the problem of negligence is a very serious problem that needs immediate attention. The focus of legislative concern should be that the malpractice system is too inaccessible, rather than too accessible, to the victims of negligent medical treatment.

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www.medicalmalpractice.com/case review.cfm

www.obgyn,net

www.consumerlaw.com/medical.html

Table 1: The table below shows the cases considered by the Disciplinary Committee in 2005 with their outcomes

NATURE OF CASE	NO. OF COMPLAINTS	CONVICTIONS					NOT GUILTY	POSTPONED TO A MEETING IN 2006
		CENSURE	CAUTION	ORDERED TO PAY COSTS	ERASURE	TOTAL CONVICTIONS		
Adulterous relationship with a patient	1	0	0	0	0	0	0	1
Advertising	3	0	0	2	0	2	0	1
Illegal Abortion	2	0	1	0	0	1	0	1
Practicing without registration	4	0	0	4	0	4	0	0
False Medical Report	2	0	0	0	0	0	1	1
Incompetence	2	0	0	0	0	0	1	1
Negligence	2	1	0	0	0	1	0	1
Practicing under influence of alcohol	1	0	0	0	0	0	0	1
Trafficking in diazepam	1	0	0	0	0	0	0	1
Unprofessional behaviour towards patient	1	0	0	0	0	0	0	1
TOTALS	**19**	**1**	**1**	**6**	**0**	**8**	**2**	**9**