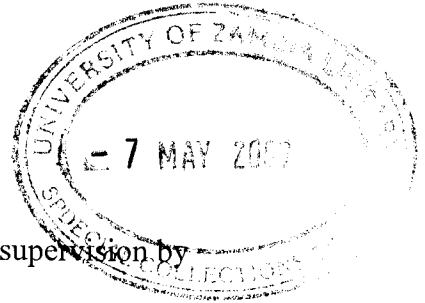


**DECLINING STANDARDS OF HEALTH CARE:
NEGLIGENCE OR MISFORTUNE?**

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2009

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I, Musonda Thabo do hereby declare that this dissertation is my authentic work and that to the best of my knowledge, information and belief no similar work has previously been produced at the University of Zambia or any other institution for the award of Bachelor of Laws degree. All other works referred to in this dissertation have been duly acknowledged.

Made this day of January 2009

By the said. 

At Lusaka.

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DEDICATION

To my parents Concepta and Brighton Musonda. You shone the light so brightly I could not help but follow.

ABSTRACT

Zambia became independent from Britain in 1964 after 40 years of colonial rule. During colonial rule the judicial administration introduced by the British in Northern Rhodesia (as Zambia was then called) through the Royal Charter of incorporation of 1889 followed the general pattern of indirect rule. At independence Zambia inherited the British system of governance and law. Among the laws that Zambia inherited was the common law relating to negligence. During the past few years, many sectors of society have expressed concern over declining standards of health care and an increase in negligence cases especially in government hospitals. According to the Medical Council of Zambia Annual Report, in the year of 2005, out of the 19 complaints reported, there was only one conviction in the case of medical negligence.

This work consists of five chapters. Chapter One identifies a number of factors that have contributed to the decline in health-care standards. It has also analyzed whether government has any legal obligation to improve the declining standards of health-care.

Chapter Two looks at the doctor patient relationship and the common law principles of negligence

Chapter Three analyzed people's attitudes towards litigation and their accessibility to the justice system when it comes to cases of medical negligence. It also discusses the judiciary's response to claims arising from medical malpractice in Zambia.

Chapter Four is a comparative analysis of judicial responses to medical negligence cases in other jurisdictions.

Chapter five consists of the conclusion and has identified opportunities for reform and made appropriate recommendations.

ACKNOWLEDGEMENTS

I would like to express my gratitude to my Mother and Father for providing the emotional, moral, spiritual and financial support.

My sisters, for loving me unconditionally, and forcing me to be a role model for them.

My brothers, for providing the technology to produce this work, and for their patience.

My friends Lunza Chigali and Chitabo Changa for always being there when I need them.

My supervisor, Professor Patrick Mvunga, for providing guidance.

To Lucy Njuka, who gave me the inspiration to write on this topic.

Lastly but not the least to My heavenly Father, Jehovah, for providing all the good gifts and all the perfect presents.

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CHAPTER ONE

1.0 INTRODUCTION

Health is the normally good condition of someone's body and the extent to which it is free from illness¹. When we talk about declining standards of health care in Zambia, we refer to the gradual weakening or decrease in quality or achievement that is considered acceptable.

The importance of good health care cannot be over emphasized. Without good health care we leave ourselves susceptible to dangerous diseases and a shortened life span. This in turn affects our economy adversely as people who are supposed to contribute to the economic development of the country die at an early age or are regularly indisposed. Good health may seem fairly easy to achieve but this is not the case with the majority of Zambians today. In this Chapter we are going to look at the main indicators of health care standards. The factors that contribute to low standards of health care in Zambia will also be considered. The Chapter will finally look at the State's legal obligations, if any, in ensuring that its citizens have access to the best health care facilities. Before this however a brief background will be given.

1.2 STATEMENT OF THE PROBLEM

There is a perceived discrepancy between the rights and duties of patients and medical practitioners and the agency entrusted with the supervision of medical practitioners. The Medical Council of Zambia is established by the Medical and Allied Professions Act to

¹ Collins Dictionary. 2002.2nd edition. HarperCollins publishers. Glasgow.

provide adequate guidance to the medical practitioners so as to uphold the high esteem of this noble profession. The Medical Council of Zambia does not seem to be adequately upholding these high standards, as negligence cases seem to be on the rise². The Council is understaffed and therefore makes it impossible for them to conduct inspections on new applications and already existing ones to ensure that standards are met and maintained.

Economic problems in the country have translated into lack of modern equipment in hospitals and thus contributing to the decline in the standards of health care. This was illustrated in the case, which occurred at Ndola Central Hospital where siamese twins died immediately after the operation because the X-ray equipment used was archaic and unable to detect that the twins shared a liver³. Findings at the University Teaching Hospital (UTH) were that it experiences numerous problems, which contribute to the high death toll, including medical malpractice. Lack of awareness by the public in terms of patients and doctors rights and duties, lack of access to justice delivery system are prevalent.

1.3 OBJECTIVES

The objectives of this study were to;

1. To establish factors which contribute to the decline in Health-Care standards.
2. To establish the Government's legal obligation with regard to providing proper health-care facilities.

² Medical Council of Zambia Annual Report of 2005.

³ Source: Ministry of Health Administration.

1.7 INDICATORS OF HEALTH CARE STANDARDS

These are sign posts that are used to establish the position or situation in the country's health care system. They show whether the situation is stable, improving or declining⁴. Three indicators have been chosen for our purposes in this study:

1.7.1 *Infant Mortality Rate*

Infant Mortality Rate (IMR) is a useful indicator of a country's level of health or development. Infant Mortality Rate is the number of newborns dying under a year of age divided by the number of live births during the year. The infant mortality rate is also called the infant death rate. The infant mortality rate is reported as the number of live newborns dying under a year of age per 1,000 live births⁵.

For the world, and for both Less Developed Countries (LDCs) and More Developed Countries (MDCs), IMR declined significantly between 1960 and 2001. World Infant Mortality Rate declined from 126 in 1960 to 57 in 2001.⁶ However, IMR remained higher in LDCs. In 2001, the Infant Mortality Rate for Less Developed Countries was about 10 times as large as it was for More Developed Countries. For Least Developed Countries, the Infant Mortality Rate is now 17 times higher than More Developed Countries. Also, while both LDCs and MDCs made dramatic reductions in Infant Mortality Rates,

⁴ Zambia Human Development Report, 2005.
⁵ http://en.wikipedia.org/wiki/Infant_mortality. September, 16th 2008

⁶ Data source: CIA World Factbook 2007

reductions among Less Developed Countries are, on average, much less than those among the more developed countries⁷.

In Zambia, the Infant Mortality Rate in 1992 was 108 per 1000 live births. The number reduced to 95 per 1000 during the year 2005. The under 5 mortality rate however has continued to be as high as 160 per 1000 live births. According to the 2001/2 Zambia Demographic and Health Survey (ZDHS), nearly 1 in 6 children born between 1997 and 2002 died before they reached their fifth birthday⁸. The report further states that child survival in Zambia is less probable today than it was ten years ago.

This is an indication that child health in Zambia has not yet reached a level that is considered acceptable. Although there has been a decrease in the Infant Mortality Rate, it is not to an acceptable level. Hence as an indicator, the Infant Mortality Rate shows that the health care system in Zambia has a long way to go before it can reach an acceptable standard.

1.7.2 Maternal Mortality Rate

Maternal mortality is another sentinel event to assess the quality of a health care system. Maternal Mortality Rate (MMR) is the rate of the number of maternal deaths per 100,000 live births in a country⁹.

⁸ Central Statistics Office .2001/2. Zambia Health Demographic Survey(ZHDS). Lusaka

⁹ http://en.wikipedia.org/wiki/maternal_mortality. September, 16th 2008

Maternal death, or maternal mortality, also "obstetrical death" is the death of a woman during or shortly after a pregnancy. In the year 2000, the United Nations estimated global maternal mortality at 529,000, of which less than 1% occurred in the developed world. However, most of these deaths have been medically preventable for decades, because treatments to avoid such deaths have been well known since the 1950s¹⁰.

High rates of maternal deaths occur in the same countries that have high rates of infant mortality reflecting generally poor nutrition and medical care.

In Zambia the Maternal Mortality Rate in 1992 was 202 per 100,000 live births in the country. The number has continued to rise with the Maternal Mortality Rates estimated at 729 per 100,000 in the year 2002¹¹. From this report it is clear that Zambia has continued to be among countries with high Maternal Mortality Rates.

This indicator also shows that the health care system in Zambia is not adequate. The Maternal Mortality Rate can be reduced to a large degree if pregnant women have access to antenatal care as soon as they know they are pregnant. This can prevent most birth related complications, thereby reducing both infant mortality and maternal mortality rates.

1.7.3 Life Expectancy

¹⁰ United Nations World Population Prospects: 2006 revision
http://www.un.org/esa/population/publication/wpp2006_Highlight_rev.pdf September, 16th 2008.

¹¹ ZHDS 2002.

Life Expectancy is the average number of years a human has before death, conventionally calculated from the time of birth, but also can be calculated from any specified age¹².

The Life Expectancy (both sexes, at birth) of the world is 65.82 years (63.89 years for males and 67.84 years for females) for 2007.

Zambia has been listed among the countries with the lowest Life Expectancy. According to the United Nations World Population Prospects of 2006, Zambia's overall life expectancy is at 38.44 years. This is very low as compared to South Africa with 42.45 years, the USA with 79.2 years and the UK with 80.53 years life expectancy¹³.

Calculating Life Expectancy from birth emphasizes contributions to improvement in health at lower ages; low pre-modern life expectancy is influenced by high infant and childhood mortality. If a person did make it to the age of forty they had an average of another twenty years to live. Improvements in sanitation, public health, and nutrition have mainly increased the numbers of people living beyond childhood, with less effect on overall average lifetimes¹⁴.

From the three indicators of the standard of health care, it is clear that the standards in Zambia are pretty low. Even though there have been improvements in recent years, they are still below the requisite standards. The fact that most of these deaths have been medically preventable for decades, because treatments for such deaths have been well

¹² http://en.wikipedia.org/wiki/List_of_countries_by_life_expectancy. September 20th 2008

¹³ http://en.wikipedia.org/wiki/List_of_countries_by_life_expectancy. September, 20th 2008

¹⁴ *ibid*

known since the 1950s shows that there is plenty of room for improvements. The Human Development Index (HDI) shows that Zambia has once again been listed amongst the countries that have been experiencing a drop in the HDI from 1980-1990 and from 1990 – 2003¹⁵. This index covers three dimensions, income, education and health. It is a barometer for changes in human well being and for comparing progress in different regions. Health indicators have remained unacceptably poor. Maternity Mortality Rate in Zambia is one of the highest in the world. The Infant Mortality Rate, malaria and tuberculosis incidences have continued to increase inspite of the assumptions made during the development of the national health strategic plan 2005.

1.8 FACTORS CONTRIBUTING TO LOW STANDARDS OF HEALTH CARE

There are a large number of factors that contribute to low standards of health care in the country. The list is inexhaustive but this work will only consider the following seven.

1.8.1 Population Increase

Zambia’s population has been on a steady increase from slightly above 10 million in the year 2000, the population of Zambia reached well over 11 million at the end of 2005¹⁶. This increase has not been met with a parallel increase in health facilities and medical practitioners. This has created a tremendous strain on the resources which are unable to cope with the increase. This has led to a situation where some people do not have

¹⁵ Zambia Human Development Report. 2005

¹⁶ [http://zamstats.gov.zm/census/census.asp\(2006,may,23\)](http://zamstats.gov.zm/census/census.asp(2006,may,23))

adequate access to health care facilities. One indicator used to assess the utilization of facilities is the bed occupancy rate. Bed occupancy rate is defined as a percentage of available beds occupied during a given period of time. Ideally, the bed occupancy rate should not be less than 80 percent. Although there are marked differences in the bed occupancy rate across the provinces, the Zambia bed occupancy rate between 2000 and 2004 appears to fall well below the ideal occupancy rate of 80 percent¹⁷. This indicator clearly shows that quite a number of people do not have access to health care facilities due to an increase in population without an equal improvement in health facilities to cater for the growing population. In 2005 there were 703 medical doctors in the country. Given a projected population of 11,297,304 in 2004, there was 1 doctor in the country per 16,000 patients which falls short of the recommended 1 doctor to 5000 patients¹⁸. The human resource shortage extends to other health workers.

1.8.2 Distribution of health care resources

The allocation of health care resources between urban and rural areas is uneven. About 80% of the medical institutions are concentrated in cities. Furthermore, high-quality medical resources tend to be congregated in large-capacity hospitals¹⁹. Patients in rural areas have a difficult time receiving timely medical assessment and care, leading to more advanced disease at diagnosis and subsequent higher medical care costs.

1.8.3 Investment in the health sector

¹⁷ Ministry of health/Central Board of Health..2004. Annual Report. Lusaka, Zambia
¹⁸ Ibid
¹⁹ Annual health statistical bulletin Ministry of Health/ Central Statistics Office.2005. Lusaka, Zambia

Another major factor that has contributed to the poor standards is that government investment in the health sector has been inadequate during the past two decades. The size and composition of the health resource envelope is inadequate and fall short of the level required to effectively support significant disease reduction. The estimated per capita resource envelope under the public health care system still remains at \$10.8 against the recommended \$33 by the WHO commission on economics²⁰. The government's under funding of the public health system has had a major influence on the prevention and treatment of epidemics and common illness, making it difficult for individuals, especially the poor living in remote rural areas, to access primary health care.

1.8.4 Supervision of Medical Practitioners

Another factor is the government's weak supervision and administration of the health care sector. The Medical Council of Zambia was established by the Medical Allied Professions Act²¹ to provide for adequate guidance to the medical practitioners so as to uphold the high esteem of this noble profession. This Council does not seem to be able to uphold these high standards, as standards are still low. The Council is understaffed and under funded.

1.8.5 Lack of Modern Facilities

Hospitals have strived to introduce modern technologies through the implementation of the Basic Health Care Package in order to achieve the required levels of efficiency and

²⁰ Ministry of Health /Central Board of Health .Annual Report. 2004. Lusaka. page 8

²¹ Chapter 300 of the laws of Zambia.

effectiveness. However, due to lack of funding they are forced to use archaic equipment. This was demonstrated in the case which occurred in 2005 at Ndola Central Hospital where Siamese twins died immediately after the operation to separate them because the x-ray equipment used was too archaic to detect that the twins shared a liver²². Hospitals have also introduced new drugs from developed countries. In most cases the hospitals do not have the relevant drugs and there have been reports of hospital staff stealing and selling to private dealers. This has led to medical costs often exceeding the economic capability of low-income families. In addition, the relatively high prices of drugs, including many common and essential drugs, have also increased patients' economic burden for health care.

1.8.6 *Lack of Health Care Insurance*

The majority of the Zambian population is not effectively covered by any form of health care insurance system. This is simply because the majority of them are poor and cannot afford to do so. Government officials, civil servants, and those working in state-owned companies are usually enrolled in the public health care insurance system but few of the absolutely poor, especially those in remote rural areas, have been brought into this system. At the same time, the commercial health insurance market is quite underdeveloped.

1.8.7 *Medical Negligence*

The final contributing factor to be considered in this research is the high levels of negligence by medical practitioners that seem to go unpunished. According to the

²² Ministry of Health .2005.Administration Report. Lusaka

Medical Council of Zambia Annual Report of 2005, out of the 19 complaints that were reported, there was only one conviction in the case of medical negligence. Chapter Two will specifically discuss in detail issues of medical negligence.

9 STATE RESPONSIBILITY

The right to adequate health care is a human right. One of the characteristics of a human right is that it is a claim upon the State. The State bears the burden to satisfy human rights claims. It must act to protect these rights and must ensure that medical care is available to citizens. In human right terms, the individuals claim is against the State and not against the health facility²³. The State must arrange institutions and domestic laws that give its citizens access to health facilities.

To ensure the fundamental rights of everyone and especially the poor to receive adequate health care, at the national level, the Zambian Constitution has in its directive principles set out a number of goals to be accomplished. The Constitution²⁴ provides that;

“The State shall endeavor to provide clean and safe water, adequate medical and health facilities and decent shelter for all persons, and take measures to constantly improve such facilities and amenities”

At the regional level, Zambia is a state party to the African Charter on Human and Peoples Rights. Under this Charter Zambia agreed to abide by *Article 16 which provides*

²³ Anyangwe. 2005 Introduction to human rights and international humanitarian law. Page 23

²⁴ Article 112 (d)

that “Every individual shall have the right to enjoy the best attainable state of physical and mental health.... States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.”²⁵

At the international level, Zambia is a member of the United Nations and pledged to take joint and separate action to promote solutions of among others health and related problems without distinction as to race, sex, language or religion²⁶.

According to the UN Convention on the Rights of a Child²⁷, to which Zambia is a state party, the child has the right to the highest standard of health and medical care attainable. The State shall place special emphasis on the provision of primary and preventive health care, public health education and the reduction of infant mortality. They shall encourage international co-operation in this regard to strive to see that no child is deprived of access to effective health services.

From the above provisions of the law we see that the state indeed does have a responsibility towards its citizens to provide them with adequate health care facilities

²⁵ African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981

²⁶ Article 55 of the United Nations Charter.

²⁷ Article 24

needed for their development. However, this duty is non justiciable. This means they cannot by themselves, despite being referred to as rights in certain instances, be legally enforceable in any court, tribunal or administrative institution or entity. The provision in the Constitution is a Directive Principle of State Policy and is meant to guide the Executive, the Legislature and the Judiciary, in the development of national policies; implementation of national policies; making and enactment of laws; and the application of the Constitution and any other law. The application of the Directive Principles of State Policy may be observed only in so far as State resources are able to sustain their application, or if the general welfare of the public so unavoidably demands, as may be determined by Cabinet²⁸

The Universal Declaration of Human Rights categorizes the right to health as an economic, cultural and social right. For it to be enjoyed there has to be expenditure of resources and this entails some cost. The obligation that has been placed on the state party is therefore relative and progressive. It is not absolute and immediate because it involves expenditure of resources and these may not readily be available²⁹. Hence the state obligation here has been qualified and progressive, depending on the resources.

Moreover, Zambia practices a dualistic system of law. In this system, a human rights treaty has domestic force only when it has been transformed into municipal law, that is to say, when parliament, by an enabling instrument, has adopted and adapted it as part of national legislation. Therefore, inspite of Zambia being party to these human rights

²⁸ Article 110 and 111 of the Zambian Constitution. Chapter One of the laws of Zambia.

²⁹ Anyangwe. page 25

treaties, they cannot be enforced against it if the Zambian legislature has not domesticated that particular treaty.

SUMMARY

A good health care system is important for the development of any society and most importantly it is a human right. Every human being has a right to access proper health facilities. The Universal Declaration of Human Rights categorizes the right to health as an economic, cultural and social right. That having been said, it is not always the case that people have access to these facilities. An indication to assess whether people have adequate access to proper health care in Zambia has been used for this research and from the information gathered, the three indicators used show that Zambia is not performing as well as it should to ensure that every citizen's right to proper health care is being satisfied. The Infant Mortality Rate in Zambia has continued to be high as can be seen from the demographic reports of 1992 and 2005. Although the rate has experienced a decrease in the Infant Mortality Rate from 108 per 1000 live births to 95 per 1000 during the year 2005, the under 5 mortality rate however has continued to be as high as 160 per 1000 live births. According to the 2001/2 Zambia Demographic and Health Survey (ZDHS), nearly 1 in 6 children born between 1997 and 2002 died before they reach their fifth birthday³⁰. The report further states that child survival in Zambia is less probable today than it was ten years ago.

³⁰ Zambia Health Demographic Survey.2002

The Maternal Mortality Rate has equally indicated that Zambia’s health system is not in good shape. The number has continued to rise from 202 per 100,000 live births in 1992 to 729 per 100,000 live births in the country in the year 2002³¹.

The life expectancy has confirmed the results of the Infant Mortality Rate and the Maternal Mortality Rate. Zambia has been rating a low life expectancy as compared to other countries. The life expectancy of the world was 65.82 years for 2007. Zambia’s overall life is at 38.44 years. This is very low compared to South Africa with 42.45 years, the USA with 79.2 years and the UK with 80.53 years life expectancy³². This is a clear indication that there is a lot of room for improving the health care facilities because all the three health indicators are determined by the standard of health care available in the country.

A number of factors have been attributed to the low standards of health care in the country. Among them is population increase. Zambia’s population has been on a steady increase from slightly above 10 million in the year 2000, the population of Zambia reached well over 11 million at the end of 2005³³. This increase has not been met with a parallel increase in health facilities and medical practitioners. This has created a tremendous strain on the resources which are unable to cope with the increase. Another factor has been distribution of health care resources. The allocation of health care

³¹ Ibid

³² ibid

³³ <http://zamstats.gov.zm/census/census.asp>(2006,may,23)

resources between urban and rural areas is uneven. About 80 percent of the medical institutions are concentrated in cities.³⁴

A further contributing factor that has contributed to the poor standards is that government investment in the health sector has been inadequate during the past two decades. The size and composition of the health resource envelope is inadequate and falls short of the level required to effectively support significant disease reduction. Hospitals have strived to introduce modern technologies through the implementation of the Basic Health Care Package in order to achieve the required levels of efficiency and effectiveness. However, due to lack of funding they are forced to use archaic equipment. The majority of the Zambian population is not effectively covered by any form of health care insurance system. This is simply because the majority of the population is too poor and cannot afford to do so.

High levels of negligence by medical practitioners that seem to go unpunished is an added factor to declining health care standards. According the Medical Council of Zambia Annual Report of 2005, out of the 19 complaints that were reported, there was only one conviction in the case of medical negligence.

³⁴ Ministry of health annual report of 2005.

The State has an obligation towards citizens to provide adequate health care. However there is no absolute obligation as this depends on the available resources. There are no standards of determining whether the resources available are actually adequate for the provision of proper health care for all citizens. Therefore there is no definite way for the citizens to coerce the State to own up to its obligations.

The available legal provisions are not binding on the state but can only act as guidelines for the government. These can either be followed or ignored. Therefore, individuals cannot bring action against the State if there are insufficient or inadequate health care facilities. Most of the factors that have been discussed as contributing to low standards in health care provision can be attributed to the lack of or availability of resources with the exception of negligence. The next Chapter will discuss the rights and duties of Doctors and patients.

CHAPTER TWO

DOCTOR- PATIENT RELATIONSHIP AND THE COMMON LAW **PRINCIPLES OF NEGLIGENCE**

0 INTRODUCTION

The relationship between physicians and their patients emphasizes the peculiar mixture of detachment and involvement of interests. This is the situation because the practice of medicine and the role of health care professionals are seen as a money-making industry and patients are seen or treated as consumers of health services. At the same time, it is believed that health care professionals should treat patients as their friends and not as consumers of services³⁵. The nature of this relationship therefore requires that it is given the appropriate care and attention by the parties involved.

This Chapter will discuss the relationship between doctors and their patients and the rights and duties that accrue as a consequence of this relationship. It will then discuss the common law principles of negligence and then narrow it down to medical negligence.

2.1 DOCTOR –PATIENT RELATIONSHIP

The doctor-patient relationship is central to the practice of medicine and is essential for the delivery of high-quality health care in the diagnosis and treatment of disease. A patient must have confidence in the competence of their doctor and must feel that they can confide in him or her. For most physicians, the establishment of a good rapport with a

³⁵ Jennifer Jackson. 2001. Truth, Trust and Medicine. New York: Routledge,p172

patient is important³⁶. The doctor – patient relationship gives rights to the patient and at the same time imposes duties on both the doctor and the patient.

RIGHTS OF THE PATIENT

2.2.1 Right to Life

The right to life is a basic human right from which other rights are derived. Article 12(1) of the Zambian Constitution guarantees the enjoyment of this right. It provides that:

“A person shall not be deprived of his life intentionally except in the execution of a court sentence in respect of a criminal offence under the law in force in Zambia of which he has been convicted.”

The central tenet of the medical profession is the preservation of the life and health of the patient³⁷. Therefore in the doctor- patient relationship, a doctor must uphold the patient’s right to life, by not intentionally taking away the life of his patient.

2.2.2 Right to Consent to Medical Procedures

Medical practitioners must get consent from their patients before diagnosing or treating them. This is because patients have the right to give or withhold consent to medical procedures. The law protects a person from medical treatment he does not want even if others think he clearly needs it. For instance in the case of **Re MB**³⁸ the Court of Appeal

https://en.wikipedia.org/wiki/Doctor-patient_relationship
kelani Banda, Ed A hand book of Medical ethics for medical students and health professionals (Lusaka; Zambia medical Association)
1997)147 NLJ 600

held that a woman with full capacity could consent to or refuse treatment even though the refusal might result in harm to her or her baby.

Patients should participate in decisions involving their health care, except when such participation is not possible for medical reasons. This is in line with the medico-moral principle of autonomy³⁹.

2.2.3 Right to Sufficient Information

A patient is an autonomous individual from both social and legal points of view and for him to make rational decisions about his illness he must be told what is wrong and how the doctor intends to help him. He must be given all the information about his disease and the management of it. This includes the modes of making a diagnosis, the diagnosis, the outcome of the disease if not treated, the modes of treatment and their outcome, the complication of treatment or diagnostic procedure. The patients consent must be obtained either verbally or in writing after the patient has had an opportunity to consider all the information. There must be constant dialogue with the patient during his or her management.

2.2.4 Right to Strict Confidentiality

The basis of the doctor-patient relationship is trust and confidentiality. Doctors take an oath at the beginning of their career which is called the Hippocratic Oath. They vow among other things not to divulge information that comes to them in the course of their

ekelani Banda, Ed A hand book of Medical ethics for medical students and health professionals (Lusaka; Zambia medical Association)

professional practice. Patients trust their doctors to protect their right to confidentiality⁴⁰. The need to keep confidential the information of their clients is termed professional secrecy and the transgression of this secrecy can lead to a practitioner being found liable of infamous conduct⁴¹. However, in certain circumstances the practitioner is obliged to disclose information regarding his patient under his care, for example before the courts of law.

2.3 PATIENT'S RESPONSIBILITIES

Apart from having rights, the patient also has responsibilities. The first responsibility he has is that of providing accurate and complete information about current and past illnesses, medications, and other matters pertaining to one's health. The second involves following the treatment plan recommended by the medical practitioner or express concern regarding one's ability to comply. Patients take responsibility for their actions if they refuse to follow the practitioner's instructions. They also have the responsibility to arrive for appointments on time and to cancel in advance if they are unable to keep the appointment⁴².

2.4 DUTIES OF MEDICAL PRACTITIONERS

The primary duty of medical practitioners should be to serve the best interests of their patients; this is best accomplished when they refrain from lying to patients, regardless of the circumstances. The duty not to lie therefore should be an absolute duty, not merely a

⁴⁰ Ibid

⁴¹ Ibid.

⁴² Sekelani Banda. Opt cit, p 85

prima facie one. Most patients want to know the truth about their illness and the treatments available, along with the side effects. It is the doctor's duty to provide such information honestly to his/her patient in a way that leads to clear understanding⁴³. The consent taken for any procedure should not be a mere formality but should be explained to the patient fully in his own language and his own level of understanding. A patient should be offered choice and alternative not in a superficial manner but in a very formal manner so that the patient has the feeling of participation in the decision making. This will to some extent depend upon the patient's intellectual capacity and social background.

The truth may be brutal but the telling of it need not be. Even if something has gone wrong, taking the patient into confidence would help in most of the circumstances unless there is an ulterior motive.

The doctor needs to pay full attention towards the patient's symptoms, his story and above all his anguish and sufferings. Listening to the patient is very important even if the diagnosis is written on his face. This is one of the failings which a doctor should avoid as this would leave the patient dissatisfied⁴⁴. After his clinical examination and required investigations, the doctor should spend time in analyzing his problems and come to a tentative or definite diagnosis depending upon the situation.

Maintenance of the patient's confidentiality is absolutely essential and should never be breached except in a court of law.

⁴³ Jennifer Jackson. 2001. Truth, Trust and Medicine. New York: Routledge, p172

⁴⁴ <http://www.tribuneindia.com/2001/200111007/spectrum/fitness.htm>. September, 20th 2008

Maintaining of a good record is very good both for the doctor and the patient perhaps even more for the doctor. This often is the saving grace for a doctor under some kind of blame⁴⁵. When the patient's needs are beyond the doctor's capacity, the doctor should refer the patient to a colleague in time and he should never sit on prestige or hold on the patient longer than required⁴⁶.

Apart from the rights and duties that have been discussed above the Common Law has also made provisions which should regulate the action of professionals including medical practitioners to ensure that they do not fail to pay enough care or attention to their patients.

2.5 COMMON LAW PRINCIPLES OF NEGLIGENCE

In common parlance, negligence is said to be the failure to give enough care or attention. In law, negligence is a tort. A tort is a civil wrong for which a remedy (usually money damages) can be obtained under the law. Professional negligence is a breach of the special duty that skilled professionals such as doctors have in excess of the ordinary person⁴⁷. Negligence is not the same as "carelessness", because someone might be exercising as much care as they are capable of, yet still fall below the level of competence expected of them. It is the opposite of "diligence". It can be generally defined as conduct that is culpable because it falls short of what a reasonable person would do to protect another individual from a foreseeable risk of harm.

⁴⁵ ibid

⁴⁶ Sekelani Banda, Ed A hand book of Medical ethics for medical students and health professionals . opt cit

⁴⁷ Pitchfork. 1995. Text book on tort. Sweet and Maxwell. London.

Negligence as a tort is defined as the breach of a legal duty to take care which results in damage, undesired by the defendant, to the plaintiff⁴⁸. This definition of negligence consists of three distinct elements; the duty of care, breach of the duty, the plaintiff must suffer damage.

2.5.1 The Duty of Care

The modern source of duty of care requirement can be found in the celebrated judgment of Lord Atkins in **Donoghue V. Stevenson**⁴⁹. Lord Atkins interpreted the biblical passages to 'love thy neighbour,' as the legal requirement 'not to harm thy neighbour.' He then went on to define neighbour as "persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions that are called in question."

This case has come to be regarded as a milestone and the above quoted passage in Lord Atkins speech is regarded as a statement of principle. Therefore, in establishing whether the duty of care arises in a particular situation the more recent case of **Caparo v. Dickman**⁵⁰ introduced a 'threefold test' for a duty of care. Harm must be (1) reasonably foreseeable (2) there must be a relationship of proximity between the plaintiff and defendant and (3) it must be 'fair, just and reasonable' to impose liability.

2.5.2 Breach of the Duty

Having established that the defendant owes the plaintiff a duty of care, the next thing to be established is whether the defendant breached that duty. Once it is established that the

⁴⁸ Winfield & jolowicz on tort. 14th edition. P 78

⁴⁹ (1932) AC 563

⁵⁰ (1990) 2 ALL ER 243

defendant owed a duty to the plaintiff/claimant, the matter of whether or not that duty was breached must be settled. The test is both subjective and objective. The defendant, who knowingly exposes the plaintiff/claimant to a substantial risk of harm, breaches that duty. The defendant who fails to realize the substantial risk of harm to the plaintiff/claimant, which any reasonable person in the same situation would clearly have realized, also breaches that duty.

An example is shown in the facts of **Bolton v. Stone**⁵¹, a 1951 legal case decided by the House of Lords, which established that a defendant is not negligent if the damage to the plaintiff was not a reasonably foreseeable consequence of his conduct. For a defendant to be held liable, it must be shown that the particular acts or omissions were the cause of the loss or damage sustained. Although the notion sounds simple, causation between one's breach of duty and the harm that results to another can at times be very complicated. The basic test is to ask whether the injury would have occurred but for, or without, my breach of duty. Sometimes 'factual causation' is distinguished from 'legal causation' to avert the danger of defendants being exposed to, in the words of Cardozo, J⁵², "liability in an indeterminate amount for an indeterminate time to an indeterminate class." It is said a new question arises of how remote a consequence a person's harm is from another's negligence. It is said that one's negligence is 'too remote' (in England) or not a 'proximate cause' (in the U.S.) of another's harm if one would 'never' reasonably foresee it happening.

951] 1 All ER 1078, [1951] AC 850

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2.6 MEDICAL NEGLIGENCE

Medical negligence often referred to as medical malpractice is professional negligence by act or omission of a health care provider in which care provided deviates from accepted standards of practice in the medical community and causes injury to the patient⁵³. The plaintiff is or was the patient, or a legally designated party acting on behalf of the patient, or in the case of a wrongful-death suit the executor or administrator of a deceased patient's estate. The defendant is the health care provider. Although a 'health care provider' usually refers to a physician, the term includes any medical care provider, including dentists, nurses, and therapists. As illustrated in **Columbia Medical Center of Las Colinas v Bush** ⁵⁴ "following orders" may not protect nurses and other non-physicians from liability when committing negligent acts. Relying on vicarious liability or direct corporate negligence, claims may also be brought against hospitals, clinics, managed care organizations or medical corporations for the mistakes of their employees.

2.6.1 Elements of Medical Negligence

For a plaintiff to succeed in his claim, he must establish all three elements of the tort of negligence. He must prove that the defendant owed him a duty of care. The duty of care that the medical practitioner owes to a patient is that which is reasonably expected from any medical practitioner in his situation. In the **Zambian case of Cicuto v. Davidson and Oliver** the High Court stated in relation to the duty of care required of medical practitioners that:

"A medical man is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of men skilled in that particular art....a man is

http://en.wikipedia.org/wiki/Medical_malpractice . September 20th 2008
2 S.W. 3d 835, Texas, 2003

not negligent, if he is acting in accordance with such a practice, merely because there is body of opinion who would like to take a contrary view."

A legal duty exists whenever a hospital or health care provider undertakes care or treatment of a patient. In the case of **Heafield V. Crane**⁵⁵, a pregnant woman was admitted to the hospital and was placed in the same ward as a woman suspected of suffering from puerperal fever. The pregnant woman contracted the disease and the Court of Appeal held that the doctor owed the patient the duty of care to ensure that he prevented her from becoming infected. The doctor was held to be negligent in not isolating her and in not taking steps to prevent her from being infected.

Having proved that the duty existed, the plaintiff must further show that the duty was breached and the provider failed to conform to the relevant standard of care. The standard of care is proved by expert testimony or by obvious errors (the doctrine of res ipsa loquitur or 'the thing speaks for itself').

The breach of duty must be a proximate cause of the injury. This means the failure to conform to the relevant standard of care must have caused the injury.

SUMMARY

In this Chapter we have established that in the doctor - patient relationship, both parties have duties that they have to accomplish for the relationship to be beneficial. Apart from duties the patient also has rights that have to be respected by the medical practitioner. We

⁵⁵ (1973)

have also looked at the Common Law position on the tort of negligence and the elements that have to be satisfied for a claim to be successful. Under negligence, the plaintiff must show that the defendant owed him a duty of care, that he failed to conform to the required standard of care and that this failure was the proximate cause of the plaintiff's injury. The general position was narrowed down to medical negligence in particular and the same elements as in the general position were used to establish medical negligence or malpractice.

Chapter Three intends to investigate people's attitudes towards litigation when it comes to cases of medical negligence. It will then analyze the legislative and judicial response to claims arising from medical malpractice in Zambia.

CHAPTER THREE

RESPONSES TO MEDICAL NEGLIGENCE IN ZAMBIA

INTRODUCTION

In the previous Chapter it was established that the traditional basis for professional liability is negligence. It was also established that medical malpractice is professional negligence by act or omission by a health care provider in which care provided deviates from accepted standards of practice in the medical community and causes injury to the patient. Thus in principle, the law of medical negligence holds health-care providers liable only for medically caused injuries that result from negligence.

The earliest relations between law and medicine were essentially regulatory. References to medicine in ancient legal sources prescribe penalties for bad practice. The Babylonian Code Hammurabi applied the principles of compensation and retribution in kind. If a slave died under medical treatment, the practitioner had to provide a replacement whereas if the patient who died was not a slave, the doctor was to lose a hand. In ancient Egypt also, a healer who lost a patient could be punished by death if he had deviated from the methods of treatment laid down in the sacred book of Hermes⁵⁶. Even in medieval times health care providers were expected to do their work within certain acceptable standards and not to deviate from these standards. They incurred liability for failing to give care or attention and for failing to follow the set regulations if a patient got injured or died in the process.

⁵⁶ Wayne . J. urban. 2002. Gender, race and the national education association. Routlege New York

Chapter Three intends to investigate people's attitudes towards litigation when it comes to cases of medical negligence. It will then analyze the legislative and judicial responses to claims arising from medical malpractice in Zambia.

PEOPLE'S ATTITUDES TOWARDS MEDICAL NEGLIGENCE

Despite the many complaints by people about medical practitioners being negligent, very few cases have actually reached the Zambian courts. There are a number of reasons why people who have experienced negligence at the hands of a medical practitioner do not bring action and seek redress in the form of compensation. A number of people who have directly experienced or whose family member has experienced medical negligence were interviewed. Three major reasons were given for not bringing action against the malpractice:

In the first instance, some people simply ignore it; they consider death as something normal and part of their lives. They reason that even if compensation was to be paid, it cannot replace the lost life or limb.

Others strongly believed that when a person dies, whether of natural causes or through negligence of a medical practitioner, it is Gods wish. Since it is Gods will, most families of the deceased do not feel the need to bring action against those responsible even if such death or deformities could have been avoided, had the proper medical precautions been taken. It is what has been destined for the victim so there is no need to punish doctors who have no hand in controlling fate.

Other Zambians are financially incapacitated to commence law suits against negligent doctors, while others did not know that they had remedies at law against this kind of professional malpractice. They were not completely aware of their rights as patients and the duty owed to them by their medical care givers.

The majority of patients who have had the chance to commence law suits prefer to settle the matter out of court.

All these attitudes show that Zambians are generally not a litigious people. In spite of these attitudes, however, a number of cases have found their way to the courts of law as will be seen later in this chapter.

LEGISLATIVE RESPONSES TO MEDICAL NEGLIGENCE

There is no specific statute which specifically deals with medical negligence in Zambia. However, a number of statutes have impliedly considered the subject of medical negligence.

The **Medical and Allied Professionals Act**⁵⁷ provides that: *if any registered person is, after due inquiry, judged by the disciplinary committee to have been guilty of infamous conduct in any professional respect, the disciplinary committee may, if it thinks fit, impose one or more of the following penalties:*

- *Direct the erasure of his name from the register,*
- *Censure him,*

⁵⁷ Section 55(1) cap 300 of the laws of Zambia.

- *Caution him and postpone for a period not exceeding one year any further action against him on one or more conditions as to his conduct during that period;*
- *Order him to pay to the council any costs of and incidental to the proceedings incurred by the council.*

This statute however does not define infamous conduct and as such leaves a lot of room for interpretation. The House of Lords in the case of **Easson v. L.N.E**⁵⁸ defined infamous conduct to mean no more than serious misconduct judged according to the rules written and unwritten, governing the profession. This definition does not make it any easy since the only rules laid down to govern the medical profession in Zambia are contained in the Oath of Hippocrates. The meaning adopted by the Medical Council of Zambia includes ethical matters such as advertising, canvassing, fee splitting, granting a certificate of illness without personal verification, abusing the dignity or privacy of a patient, personal misuse of alcohol, failure to report professional misconduct of a colleague, and forgery⁵⁹. Medical negligence or malpractice has not been explicitly included in all these definitions of infamous conduct.

Another statute which impliedly considers the question of medical negligence is the **Penal Code**⁶⁰. Section 199 provides that *any person who by any unlawful act or omission causes the death of another person is guilty of the felony termed manslaughter.*

⁵⁸ (1944)2 K.B 421

⁵⁹ Sekelani Banda, Ed A hand book of Medical ethics for medical students and health professionals (Lusaka; Zambia medical Association)

⁶⁰ Chapter 87 of the laws of Zambia.

Culpable negligence to discharge a duty tending to the preservation of life or health, whether such omission is or is not accompanied by an intention to cause death or bodily harm, amounts to an unlawful omission.

Section 210 also imposes a duty of care. It provides among other things, that it is the duty of every person having charge of another who is unable by reason of age, sickness or unsoundness of mind whether it is imposed by law, or arises by reason of any act, whether lawful or unlawful to provide for such person the necessities of life; and he shall be deemed to have caused any consequences which adversely affect the life or health of the other person by reason of any omission to perform that duty. From this section it is clear that the medical practitioner shall be held criminally liable for negligence if he fails to exercise care towards the patients who are under his care.

On account of this gap in Zambian legislation pertaining to medical negligence or malpractice, the courts of law apply the common law principles of negligence in cases of medical negligence. We shall now analyze the judicial response to medical negligence in Zambia. We shall then compare it with that of the United Kingdom, the United States of America and the nearby South Africa.

THE JUDICIAL RESPONSES TO MEDICAL NEGLIGENCE

The Zambian courts have time and again applied the common law principles of negligence in cases of professional negligence. The duty of care has been applied both in ordinary and

professional negligence cases following the celebrated case of **Donoghue v. Stevenson**⁶¹. This can be seen in the cases of **Michael Sata v. Zambia Bottlers**⁶² and **Edna Nyasulu v. Attorney General**. In the latter case, it was held that where proof of professional negligence is concerned, the court will not draw an inference of negligence in cases involving professionals unless there is direct evidence, on a balance of probabilities. The 'Bolam principle'⁶³ was used in the **Cicuto v. Davidson and Oliver**⁶⁴ in relation to the standard of care required of medical practitioners. This principle stated that:

"A medical man is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of men skilled in that particular art.....a man is not negligent, if he is acting in accordance with such a practice, merely because there is body of opinion who would like to take a contrary view."

The Court in this case stated that the practice is right if a body of respectable and responsible men under the same circumstances would have followed the same procedure.

The attitude of the courts has been protective of medical practitioners in Zambia as can be seen in the case of **Edna Nyasulu v. Attorney General**. In this case the Court stated clearly that it will not draw an inference of negligence in cases involving professionals unless there is direct evidence to prove it. The need for direct evidence in this case raised the standard of proof almost to that required in criminal cases, that is to say, proof beyond reasonable doubt.

⁶¹ (1932) AC 563

⁶² SCZ No. 1 of 2001

⁶³ Bolam v. Friern (1957) 1 WLR 583, 587

⁶⁴ (1968) ZR HC

Medical negligence is a tort and the standard of proof required is that on the balance of probabilities. If this standard is not observed, medical practitioners would escape liability unless if the case is extremely obvious. Moreover if the standard is as high as was set in the case of **Cicuto v. Davidson and Oliver**, medical practitioners would hide behind the guise of 'acceptable practice' in order to escape liability.

SUMMARY

Different attitudes exist in different sectors of society. From a survey that was carried out it was observed that Zambians are generally not a litigious people. Different people had different reasons for not bringing action against the negligent medical practitioners. Others opted for ex curia settlements. In spite of this trend in attitudes there are some people who would like to get justice through the courts of law as can be observed from case law.

By contrast with the judiciary, the legislature has not been vigilant in enacting laws and amending the already existing laws to regulate the medical profession. Legislation regulating this profession is almost non-existent and the little that exists is not adequate and only makes indirect reference to the issues of medical malpractices.

The judicial system however has been vigilant as demonstrated by cases that have been brought before the Court. Since legislation governing the medical profession is almost non-existent, they have used the principles of English Common Law in adjudicating over the

cases that come before the Court. There has however been an observable trend to lean in favour of medical practitioners in medical negligence cases. This has been done by raising the standard of proof and also by allowing medical practitioners to hide behind the guise of 'acceptable practice' in order to escape liability.

Having looked at the different attitudes prevailing in Zambia, the next Chapter intends to analyze these attitudes at an international level so that we learn from our counterparts in other jurisdictions.

CHAPTER FOUR

A COMPARATIVE ANALYSIS OF RESPONSES TO MEDICAL NEGLIGENCE

INTRODUCTION

In the previous Chapter the Zambian judicial system responses to medical negligence was analyzed. Courts in Zambia deal vigilantly with the cases that come before them. People's attitudes towards litigation of medical malpractice were also considered. Since legislation governing the medical profession is almost non existent, the courts use the principles of English Common Law in adjudicating cases that come before them. There has however been an observable trend to lean in favour of medical practitioners in medical negligent cases. This has been done by raising the standard of proof and also by allowing medical practitioners to hide behind the guise of 'acceptable practice' in order to escape liability.

Having looked at the different attitudes prevailing in Zambia, this Chapter intends to analyze the attitudes toward medical negligence at an international level. The countries to be analyzed will include the United Kingdom, the United States of America and South Africa. We shall then compare these with Zambia in order to determine whether our system needs any changes in its attitude towards medical negligence.

The trend of recent authority in the United Kingdom, United States of America and South Africa has been to extend liability and to reduce immunities, even where the law formerly provided these. Trends in the common law seem to be running against immunity. The

issue at hand seems to be whether there are any lessons to be learnt from the experiences of these foreign jurisdictions.

1 THE UNITED KINGDOM

There is growing evidence that mistakes having serious consequences do occur in medical practice. Because of the nature of health care, mistakes often have serious effects for patients and their families. It was estimated in the UK alone that up to 40,000 patients die annually as a result of medical errors⁶⁵. Governments are much more aware now than they were of the infallibility of medical diagnosis and treatment and the justification of facilitating legal redress in at least serious cases.

The consciousness of rights by citizens has also been more clearly established. This can be seen in the comment made by the Court in the 1959 case of **Agnew v. Parks**⁶⁶. The Court stated that,

"we are acutely aware of the problems arising out of the steadily increasingly volume of negligence actions plaguing doctors and that they more than any other profession because of the serious personal nature of their services, are subject to attack by many unfounded claims of malpractice; but it cannot be denied even by the profession itself that there are also many claims of substantial merit."

⁶⁵ Charles Vincent (Dr.)1999.. Clinical risk unit. university college of London

⁶⁶ (1959)CA 2

There has not only been a growing demand for accountability of medical practitioners but they have also been subjected to constant scrutiny and have been made liable much more than they were in the past. In a 1975 case **Madison v. Rawlings Mark**⁶⁷, the courts awarded 3000 pounds to the parents of a child whose leg was amputated due to the negligence of the medical practitioners who conducted the operation. In a similar Zambian case which occurred almost at the same time, of **Paul Lubasi v. Patel**⁶⁸, K1, 000-00 was awarded to the plaintiff for negligence of a medical practitioner at UTH who failed to detect a glass stuck in his thigh. The wound became septic and the whole leg had to be amputated.

In the 1994 case of **Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital**⁶⁹ the trial court entered judgment against the hospital in excess of the amount the employee would have been entitled to recover under MICRA had she sued the hospital and physician and won. Court of Appeal affirmed. Supreme Court reversed, holding that MICRA's \$250,000 limit on recovery for noneconomic damages in an action for professional negligence against a health care provider applies in an action for equitable indemnity brought by a settling tortfeasor against a health care provider.

From the above cases it is clear that the courts in Zambia, England and the United States of America do not hesitate to hold medical practitioners liable for acts done. However it is observed that English courts show more seriousness and seem to uphold the idea that

⁶⁷ (1975)QBD 20

⁶⁸ (1973) unreported. Source Medical Council of Zambia

⁶⁹ (1994) 8 Cal.4th 100

professional negligence should be discouraged than the Zambian courts. This is seen in the disparity in the quantum of damages from the above cited cases which are very similar. While it is appreciated that the question of quantum largely depends on the case at hand and just how serious or extensive the effect it has on the patient or his family, the amounts awarded for cases arising out of medical malpractice in Zambia is far below the amount awarded by the courts in England.

2 THE UNITED STATES OF AMERICA

Prior to the early 1800's, medical malpractice was almost unknown in the United States. However, a large number of malpractice law suits inundated the courts between 1835 and 1865. About 70 to 90 percent of the litigation involved fractures and dislocations with imperfect results or deformities such as shortened or crooked limbs. Today at least 44,000 – and as many as 98,000 – patients die in hospitals each year as a result of preventable medical errors. Even if the lower estimate is used, deaths as a result of medical errors are the eighth leading cause of death in America⁷⁰. This has led to the refinement of enforcement mechanism in the US, which have now become quite efficient. The reality of this state of affairs is that medical practitioners have been confronted with insurance premium increases of up to 30% annually⁷¹. The approach

⁷⁰ Institute of Medicine, To Err is Human: Building a Safer Health System (November 1999)

⁷¹ Source; jutta kath's article based on a presentation, managers, claims services on the occasion of the conference. "learning from mistakes ; incident reporting risk management, cost reduction" at the university hospital; in Zurich 23rd march, 2004.

taken is not different from that in the UK and other jurisdictions. It is equally important to take steps that will reduce the likely hood of harm being done in future.

Like in the United Kingdom, the consciousness of rights by citizens has also been more clearly established. Most people are 'suit conscious,' they are conditioned to demand their full legal rights when ever the opportunity is afforded them. This tendency to sue for damages the moment such rights are thought to have been compromised was discussed in **Doctors and Professional Negligence**⁷²,

"The reasons for the recent effervescence of litigation directed against doctors are many ...a fifth is a psychological factor which also springs from the welfare state and the mentality it engenders. The attitude of mind common in particular sections of the community that if anything goes wrong someone should be made to recompense them by the payment of damages. This attitude gives rise to hundreds of claims which are ill founded. It also tends to lead to a legal claim being brought every time there is a real or imagined complaint in respect of medical treatment."

Having acknowledged that some claims for medical negligence are well founded, the courts have been moving away from the traditional attitude of giving immunity to health institutions in negligent cases. Even that which was granted to charitable institutions has over the years been removed. Various reasons had been advanced in attempts to justify the immunity from tort liability of charitable institutions⁷³. Whatever the practical value of

⁷² 71 scot LR 177 (1955)

⁷³ Harper & James. 1956 . Torts. 1667,1671.

the immunity rule in an earlier era in fostering the development of needed hospitals, the reasons advanced for it have been analytically weak and offensive to a refined ethical sense. Many courts aptly expressed their refusal to accept in modern times a doctrine which is inconsistent with today's sense of social responsibility partially in view of the increasing imposition of liability for tortuous conduct in other areas of law. This was expressed in the case of **Sisters of the Sorrowful Mother v. Zeildler**⁷⁴ where the Supreme Court of the State of Oklahoma stated,

"We cannot accept the doctrine that charitable hospitals should be exempt from liability for injuries caused by the negligence of servants, agents, and employees of such hospitals. Such doctrine is repugnant and shocking to a sense of fairness and justice of the victims of what may aptly be termed protected negligence."

Recent Supreme Court decisions like **Rush Prudential HMO, Inc. v. Moran**⁷⁵ have continued to recognize that it is appropriate for the states to handle health accountability matters because health care is an area traditionally left to the states to regulate.

In Zambia, most negligence cases occur in government hospitals which although not being charitable hospitals also operate at a very low cost to enable even the poor to have access to medical care. In spite of the low costs, these too should be held liable for the injuries inflicted on their patients due to negligence on their part. They have a social responsibility to ensure that the services they provide to the public do not lead to further

⁷⁴ 183 OKLA 454 (1938)

⁷⁵ , 122 S.Ct. 2151 (2002)

harm that can be prevented. Exempting or shielding such institutions and their medical practitioners from liability is against a sense of fairness and justice of the victims and their families. It is thus trite that when harm is done, it is important that acceptable remedies be applied to undo the harm as much as possible. If this harm is caused by medical negligence, those responsible should be held liable and the victims of injury awarded appropriate compensation.

SOUTH AFRICA

The problems of medical negligence are not restricted to developed countries. Like many other countries, South Africa has had to deal with the issue of medical negligence. Again the approach taken by the South African courts has not been very different from that of the English courts. This can be observed in the case of **Leonidas Souzou Michael and Thelma Michael v. Links field park clinic ltd and Dr. Hugh Thomas**⁷⁶. In this case medical negligence was alleged against the defendants. The courts observed that although it is often said in South African courts that the governing test for professional negligence is the standard of conduct of the reasonable practitioner in the particular professional field, the court in this case alluded to the decision of the **House of Lords** in the case of **Bolitho v. City and Hackney Health Authority**⁷⁷. It was stated in the latter case that the court is not bound to absolve a defendant from liability for alleged negligent medical treatment or diagnosis just because of evidence of expert opinion albeit genuinely held,

⁷⁶ Case no. 36/98 supreme court of south Africa

⁷⁷ (1997)

that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis. In other words the expert has considered comparative risks and benefits and has reached a defensible conclusion. If the body of professional opinion overlooks an obvious risk which could have been guarded against, it will not be reasonable, even if almost universally held.

From this case it is clear that South Africa is running against immunity of medical practitioners. This position is quite different from that of Zambia where the trend is to allow medical practitioners to hide behind the guise of 'acceptable practice' in order to escape liability. This was observed in the case of **Cicuto v. Davidson and Oliver** in relation to the standard of care required of medical practitioners. The 'Bolam principle'⁷⁸ was used. It stated that;

"A medical man is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of men skilled in that particular art....a man is not negligent, if he is acting in accordance with such a practice, merely because there is body of opinion who would like to take a contrary view."

The principle used in this case is a 1957 but this principle has since been changed by the later case of **Bolitho v. City and Hackney Health Authority**⁷⁹ in which it was stated that the court is not bound to absolve a defendant from liability for alleged negligent medical treatment or diagnosis just because of evidence of expert opinion albeit

⁷⁸ Bolam v. Friern (1957)1 WLR 583 , 587
⁷⁹ (1997)

genuinely held, that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis. Therefore from this position medical practitioners cannot hide behind the guise of 'acceptable practice' in order to escape liability.

COMPARATIVE ANALYSIS

From the above case studies it has been established that the trend has been to make health practitioners liable for any serious malpractice committed. The United Kingdom has over the years been changing its conception of medical negligence and liability thereof. These transitions can be seen in the cases of **Bolam v. Friern** in 1957 and the much recent case of **Bolitho v. City and Hackney Health Authority** a recent case. There has not only been a growing demand for accountability of medical practitioners but they have also been subjected to constant scrutiny and have been made liable much more than they were in the past.

The United States have not remained stagnant with regard to these dilemmas of medical malpractice. A large number of malpractice law suits inundated the courts between 1835 and 1865 and the trend has continued up to date. The courts have been moving away from the traditional attitude of giving immunity to health institutions for negligent cases. Exempting hospitals and medical practitioners from liability has come to be viewed as repugnant and shocking to a sense of fairness and justice of the victims of what may aptly be termed protected negligence. This attitude has led to the refinement of enforcement mechanism in the US which have now become quite efficient.

South Africa has not been let behind either despite being a developing country. South Africa has been running against immunity of medical practitioners towards liability for negligent acts causing injury to patients. Again the approach taken by the South African courts has not been very different from that of the English courts.

Generally, the attitudes that have been exhibited by the above countries are not very different from Zambia. However a few lessons can be learnt from these jurisdictions. The first is the public attitude towards litigation. The countries referred to show that the consciousness of rights by citizens is more clearly established. Most people are 'suit conscious,' they are conditioned to demand their full legal rights when ever the opportunity is afforded them.

This attitude is quite different from that prevailing in Zambia as we saw in the previous chapter. In the first instance, some people in Zambia simply ignore medical malpractice; they consider death as something normal and part of their lives. They reason that even if compensation was to be paid, it cannot replace the lost life or limb. Others strongly believe that when a person dies, whether of natural causes or through negligence of a medical practitioner, it is God's wish. Since it is God's will, most families of the deceased do not feel the need to bring action against those responsible even if such death or deformities could have been avoided, had the proper precautions been taken. It is what has been destined for the victim so there is no need to punish doctors who have no hand in controlling fate. Others were simply not completely aware of their rights as patients and the duty owed to them by their medical care givers.

Another issue that was observed is that of the quantum of damages awarded to victims of medical negligence. It has been observed that while it is appreciated that the question of quantum largely depend on the case at hand and just how serious or extensive the effect it has on the patient or his family, the amounts awarded for cases arising out of medical malpractice in Zambia is far below the amount awarded by the courts in England or the other jurisdictions that have been considered. The purpose of damages in tort is to put the victim back in the position he would have been had the tort not have been committed. This however is rarely possible in most medical negligence cases to put the person back in the position they were in before the injury occurred. This is simply because compensation cannot replace the lost life or limb. However, the amount of compensation should be appropriate to mitigate the loss and hardship that the victim and his family have suffered and is likely to suffer in future.

The position in **Bolitho v. City and Hackney Health Authority** is progressive and could be applicable to Zambia. In this case, the Court stated that it was not bound to absolve a defendant from liability for alleged negligent medical treatment or diagnosis just because of evidence of expert opinion, albeit genuinely held, that the treatment or diagnosis in issue accorded with sound medical practice. This progressive attitude would prevent medical practitioners from hiding behind the guise of 'acceptable practice' in order to escape liability. They would become more careful and conscious of the social responsibility.

SUMMARY

The interventions that have been adopted by the various jurisdictions have included deliberate legislation and policy pronouncement as well as judicial activism manifest in court decisions. All the jurisdictions that have been considered herein are extending liability for medical negligence and reducing immunities. Zambia would therefore do well to learn from these experiences.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 CONCLUSION

A number of conclusions have been drawn from the study that was conducted. It has been established that a good health care system is important for the development of any society and most importantly it is a human right. Every human being has a right to access proper health facilities. The Universal Declaration of Human Rights categorizes the right to health as an economic, cultural and social right. This right is hard to justify because it needs a lot of expenditure on the part of the government and even among so called developed countries, not everyone has access to free medical care. That having been said, it is not always the case that people have access to these facilities.

An indication to assess whether people have adequate access to proper health care in Zambia has been used in this research and from the information gathered, the three indicators used show that Zambia is not performing as well as it should to ensure that every citizens right to proper health care is being satisfied. The Infant Mortality Rate in Zambia has continued to be high as can be seen from the demographic reports of 1992 and 2005. Although there has been a decrease in the Infant Mortality Rate from 108 per 1000 live births to 95 per 1000 during the year 2005, the under 5 Mortality Rate however has continued to be as high as 160 per 1000 live births. This is a clear indication that there is a lot of room for improving the health care facilities because all the three health indicators are determined by the standard of health care available in the country.

study identified five factors that can be attributed to the low standards of health care in the country but the list is inexhaustible. The first factor that was identified is Population increase. The second factor is the distribution of health care resources. The third major factor that has contributed to the poor standards is that government investment in the health sector has been inadequate during the past two decades. The fourth is that the majority of the Zambian population is not effectively covered by any form of health care insurance system. This is simply because the majority of the population is too poor and cannot afford to do so. The fifth contributing factor is the high levels of negligence by medical practitioners that seem to go unpunished. According to the Medical Council of Zambia Annual Report of 2005, out of the nineteen complaints that were reported, there was only one conviction in the case of medical negligence.

It has been evaluated from the provisions of the law on the State's responsibility, the Universal Declaration of Human Rights and the Constitution categorizes the right to health as an economic, cultural and social right. Hence the State obligation here has been qualified and progressive, depending on the resources. This means that the state cannot be held liable for any harm that may result from lack of proper health care provisions. The Constitution states clearly that the provision is a Directive Principle of State Policy and is meant merely to guide the Executive, the Legislature and the Judiciary, in the development of national policies; implementation of national policies; making and enactment of laws; and the application of the Constitution and any other law. Therefore, individuals cannot bring actions against the State if there are insufficient or inadequate health care facilities. Most of the factors that have been discussed as contributing to low standards of health care provision can be attributed to the lack of or availability of resources with the exception of negligence.

adjudication. There has however been a trend to lean in favour of medical practitioners in medical negligent cases. This has been done by raising the standard of proof and also by allowing medical practitioners to hide behind the guise of 'acceptable practice' in order to escape liability.

The study went further to investigate people's attitudes at an international level and it was established that people in the countries used as case studies were quite litigious when it came to medical negligence cases. It was also established that the interventions that have been adopted by these jurisdictions have included deliberate legislation and policy pronouncement as well as judicial activism manifest in court decisions. All the jurisdictions that were considered are extending liability for medical negligence and reducing immunities.

5.2 RECOMMENDATIONS

The first recommendation that is made by the author is that the social, economic and cultural rights should be included in Part III of the Constitution and become binding on the state. This will improve the health condition of the country because it will be treated by the State as an emergency and not just as a directive principle of state policy. The state will be obliged to build more hospitals and also to improve the already existing ones. It would also need to ensure that there are more medical personnel in health institutions in Zambia and reduce incidences of brain drain in the medical field.

Even though the State may claim not to have corresponding resources, improvement of health care should be a priority before they contemplate increasing salaries for constitutional office holders.

The legislature should amend or enact an entirely new Medical Practitioners Act which should provide clear and precise provisions that will guide the conduct of medical practitioners and also ensure that high standards are maintained in this noble profession. The Council has to be clothed with statutory powers for it to be effective and efficient.

Although Common Law principles have been followed by the courts when adjudicating on issues of negligence, the legislature may also enact statutes that deal with medical negligence or misconduct that are specifically tailored to our environment and circumstances. For instance it should be an offence for medical staff to make a seriously ill patient to stand on the queue and wait his turn when his case is an emergency.

The other recommendation is that the state should make deliberate interventions that have been adopted by other jurisdictions such as the United Kingdom, the United States of America, and South Africa. These should include deliberate legislation and policy pronouncement as well as judicial activism manifest in court decisions. The Court should further extend liability for medical negligence and reduce immunities.

If these recommendations were to be implemented, the health conditions in the country would improve tremendously and the indicators would record positive changes. This would in turn lead to higher productivity and development.

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APPENDIX

INTERVIEW QUESTIONS

1. Have you or your family members been victims of medical negligence?
2. What action if any did you take against the hospital?
3. Why did you take such action?
4. Would you take the same action if it happened again?

Five respondents were interviewed.

ANSWERS TO THE QUESTIONS

Question 1

All respondents had family members who were victims of medical negligence. Two had resulted in death.

Question 2

Three of the respondents took no action. One went to legal resource foundation but did not pursue the matter any further. The other one wrote a letter of complaint to the ministry of health but no response was ever received.

Question 3

Three of the respondents who took no action said it was God's will for the injury to happen hence nothing could change that. The other two said that if the hospital had been careful, the injury would not have taken place.

Question 4

Three respondents said that they would just leave matters as they are again. One respondent said if they had money they would sue the hospital. Another one said he would beat up the doctor in charge since that is when the authorities seem to pay attention.

PARTICULARS OF THE RESPONDENTS

Mrs Njuka	Mrs. Kapya	Mr. Namutabo	Mr. Tembo	Mrs. Chanda
Daughter given wrong medicine	Husband died on the hospital queue.	Son given wrong medicine	Wife died during child birth	She was given a wrong diagnosis.
Kalingalinga hospice	Kaunda square stage 2	Kaunda square stage 2	Kaunda square stage 2	Minestone, chainama.
Interviewed on august 23 rd 2008	Interviewed on august 25 th 2008	Interviewed on September 1 st 2008	Interviewed on September 1 st 2008	Interviewed on September 5 th 2008