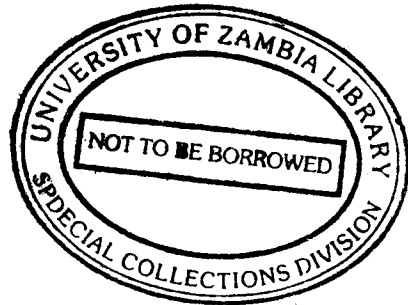


PROFESSIONAL NEGLIGENCE IN ZAMBIA: AN  
APPRAISAL OF THE MEDICAL PROFESSION

BY



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A dissertation paper to be submitted to the School of law of the University of Zambia in  
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# THE UNIVERSITY OF ZAMBIA

## SCHOOL OF LAW

I recommend that the obligatory essay prepared under my supervision by

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Entitled

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## DECLARATION

I, **MAYAMBA MWANAWASA**, do declare that the contents of this dissertation are entirely based on my own findings and that I have not in any respect used any person's work without acknowledging the same to be so.

I therefore bear the absolute responsibility for the contents, defects and omissions therein.



.....  
SIGNATURE

30<sup>th</sup> November, 2005

.....  
DATE

# DEDICATION

## **TO My late Dad, Harry Patrick Mwanawasa (1954 to 2005).**

Dad tears may be dry, but it is really hard to cope without you.  
I wish you were around to witness my graduation, but the Lord thought it was the best  
time for you to live.

Thank you for the confidence that you had in me since childhood to pursue the LL.B  
programme;

Thank you for being my friend, and despite all the pressure I put you through, you still  
believed in me;

Thank you, for all the love and care you showered on me.

May your soul rest in eternal peace!

## **TO My Mum, Regina Chilufya Mwanawasa**

Mum, you have been a great source of inspiration to me. You have taught me to be strong  
when times are hard, for the sake of my future and my siblings.

Because of the love you have showered me, I know better what it means to love.

You are always interested in knowing what and how I am doing academically and when I  
will become a Lawyer.

Dad and Mum, you have always wanted me to attain the highest level of education; here  
is partial fulfillment of your desire for me!

**I LOVE YOU**

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# CHAPTER ONE

## THE MEDICAL PROFESSION IN ZAMBIA

### 1.0 Introduction

Before we can clearly understand the subject of medical negligence, it is important to have foreknowledge of the medical profession in general. Therefore, the first chapter will discuss the various types of medical personnel involved in the complex medical health care system. The chapter will also discuss the doctor-patient relationship.

The characteristic features of the medical profession are determined largely by the attitude of society towards the human body and the valuation of health and disease. The scope of medicine was always the same: to cure disease and eventually to prevent it. Medicine always meant service; therefore, at all times certain qualities were required of the physician- readiness to help, knowledge concerning the nature of disease, and skill in curing the sick man.<sup>1</sup>

Doctors have a special and privileged position within society, which is based around notions of professionalism. These notions include the idea that society places its trust in the medical professional to hold special areas of knowledge and skill and those members of the medical profession are expected to act virtuously to use that knowledge and skill for the benefit of society. Doctors are expected to fill in for their patients the very same way that lawyers fill for their clients. This role is necessary, because sick people are no

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<sup>1</sup> Henry E. Sigerist, "The Physicians Profession through the ages," in Henry E Sigerist on the History of Medicine, ed Felix Marti Ibanez (Newyork: MD Publications 1960, p3

more capable of navigating the complex health care system, than are accused persons capable of navigating the complex legal system.

The importance of the medical profession cannot be over emphasized but it is important to state that every person in society has at least some physical contact with such persons during their lifetime. Medical health Practitioners are important because they hold the patients life in their hands. They are trained to treat patients and if they are careless or negligent, such lives may be lost. In short, it can be stated that the medical profession serves a fundamental role in our society and has an effect upon all our lives.

### **1.1 WHO IS A MEDICAL PRACTITIONER**

The common conception of the Zambian society is that doctors are the only medical practitioners and most Zambians attach the title of 'doctor' to any person who actually treats them or comes into direct contact with them when they are ill or suffering from injury in hospital. The courtesy title of 'doctor' is commonly applied to all registered medical practitioners, except consulting Surgeons, whether or not they hold the degree of doctor of medicine.<sup>2</sup> The expression 'medical' in this paper is used in the widest sense. It does not only relate to Surgeons, but also to Dentists, Nurses, Midwives, Radiographers, Clinical Assistants and all others who give medical advice or treatment.

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<sup>2</sup> J. Mumba "The Medical Practitioner", 14 **MEDICAL JOURNAL OF ZAMBIA** No. 1 (Doc/1979/Jan/1980) p1

The term 'medical practitioner' is not defined under the Medical and Allied Professions Act.<sup>3</sup> However, the Medical Council of Zambia is established under section 3 of the Act to register the following in the medical profession:

- (a) Medical practitioners
- (b) Dental surgeons
- (c) Pharmacists
- (d) Nurses and midwives

The Council may pursuant to Section 16(2) of the Medical and Allied Professions Act prepare and maintain a register of the following:

- (a) Opticians
- (b) Physiotherapists
- (c) Radiographers
- (d) Occupational therapists
- (e) Medical laboratory technologists
- (f) Dental technicians
- (g) Medical assistants
- (h) Dental auxiliaries
- (i) And nursing auxiliaries

It must be pointed out that medical practitioners do not perform duties individually. The modern practice of medicine emphasizes treatment of the patient as a whole. It brings into play all the skills and techniques of physicians, Surgeons, Nurses, Dentists, Midwives, Radiographers and other medical practitioners. A doctor may not be trained in properly taking x-ray films and so the Radiographer is important in this area.

A lot of difficulties will arise if we try and give a precise meaning to the Phrase 'Medical Practitioner'. What is important for purposes of this discussion is to look at how liability

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<sup>3</sup> Chapter 297 of the Laws of Zambia

arises with the different medical personnel and what their function are in the medical field and the role they play in the practice of medicine. For purposes of medical negligence, we will look at Physicians, surgeons, Radiographers, Psychiatrists, Nurses and medical assistants

## **1.2 TYPES OF MEDICAL PRACTITIONERS**

### **1.2.1 Physicians and Surgeons**

Physicians diagnose illnesses, prescribe, and administer treatment for patients suffering from injury or disease. They also examine patients, obtain medical histories, order, perform and interpret diagnostic tests. They counsel patients on diet, hygiene and preventive health care.

Surgeons are physicians who specialize in the treatment of injury, disease and deformity through operations. Using a variety of instruments, and with patients under general or local anesthesia, a surgeon corrects physical deformities, repairs bone and tissue after injuries, or performs preventive surgeries on patients with debilitating diseases or disorders. Like primary care givers and other specialist Physicians, Surgeons also examine patients, perform and interpret diagnostic tests, and counsel patients on preventive health care. Although a large number perform general surgery, many surgeons choose to specialize in a specific area. One of the most prevalent specialties is orthopedic surgery: the treatment of the skeletal system and associated organs. Others include neurological surgery (treatment of the brain and nervous system), ophthalmology (treatment of the eye), and otolaryngology (treatment of the ear, nose and throat) and plastic or reconstructive surgery.

Physicians and Surgeons owe a duty to show care and reasonable skill in their professional relations with their patients, and in respect of any breach of that duty, the patient can sue in tort for damages.

### **1.2.2 Nurses and Medical Assistants**

Nurses and medical assistants perform many duties and Doctors assign some of these duties to them. They usually perform duties such as giving injections, giving prescribed drugs to patients and looking after the general welfare of patients. Like other medical Practitioners, Nurses and other medical assistants also owe the patient a duty of care in the way they perform the duties assigned to them.

### **1.2.3 Radiographers and Medical Laboratory Technologists**

Before a Physician or a Surgeon can proceed in their work, Radiographers and Laboratory Technologists do a lot of primary work. For instance, before carrying out an operation, a Surgeon may want to take x-ray pictures and all this has to be done by a Radiographer, who is a qualified x-ray technician. Similarly, a Doctor may want certain samples tested before treatment and the Laboratory Technologists will test these. Like all other medical personnel, Radiographers and Laboratory Technologists also owe the patient a duty to take care.

### **1.2.4 Psychiatrists**

Psychiatrists are the primary caregivers in the area of mental health. They assess and treat mental illnesses through a combination of psychotherapy, psychoanalysis, hospitalization and medication. Psychoanalysis involves long-term psychotherapy and counseling for patients. In many cases, medication is administered to correct chemical imbalances that

may be causing emotional problems. Psychiatrists may also administer electroconvulsive therapy to those of their patients who do not respond to, or who cannot take, medication.

A number of medical specialists including allergists, cardiologists, dermatologists, Emergency Physicians, gastroenterologists, pathologists, and radiologists also work in clinics, hospitals and private offices.

### **1.3 DOCTOR-PATIENT RELATIONSHIP**

For the relationship between the medical professional and society to be functional, both parties should hold a core set of values and beliefs in common. The practice of medicine is a social task in which the patient and the doctor must respect each other's personal morality. While health care providers cannot ethically impose their own personal morality on the patient, neither can the patient ask physicians to violate their own personal morality. They carry the heavy responsibility in trying to resist the dictates deemed harmful to their patients.<sup>4</sup> Whenever you are a patient, the traditional doctor-patient relationship guarantees that there is at least one knowledgeable professional who is looking out, above all, for your interests.

In examining the legal relationship between the medical practitioner and the patient, it might be helpful to begin by reviewing a "philosophical" analysis of the relationship,

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<sup>4</sup> R.K Nayak "**Medical Negligence, patients safety and the law**" Regional Health Forum WHO South East Region. Vol 8 Number 2, 2004

which was reported by Szasz and Hollender.<sup>5</sup> These authors describe distinct patterns (or models) the doctor -patient relationship may take.

The traditional pattern according to the authors is described as one of “Activity-Passivity”. Characteristic of this pattern is the emergency situation of the patient on the operating table. As stated by the authors, such a model “places the doctor in absolute control of the situation. It is based on the effect of one person on another in such a way and under such circumstances, that the person acted upon is considered inanimate or is unresponsive. Under this model, the patient is looked at, as an inert being that has no control over itself.

The second pattern, one that underlies much of medical practice is described as “guidance-cooperation” and is employed in situations less desperate than the first model. “Although the patient is ill, he is conscious and has feelings and aspirations of his own. Since he suffers pain, anxiety and other distressing symptoms, he seeks help and is ready and willing to cooperate....”<sup>6</sup> Under this model, the Pphysician tells patient what to do, and the patient cooperates.

Because of the dominance of the doctor in both the “Activity-Passivity” and “Guidance-Cooperation” models, the ethical standards of the profession require that the Doctor considers himself in a position of trust. For instance, in its first sentence, the Code of American Medical Association speaks of the objective of “Service to humanity with full

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<sup>5</sup> T.S Szasz and M.H Hollender, “A Contribution to the Philosophy of Medicine-The basic Models of the Doctor Patient Relationship, 97 Archives of Internal Medicine, 585

<sup>6</sup> *ibid* at p586

respect for the dignity of man”. It talks of patients entrusted to the care of Physicians and of the Physician meriting the confidence of patients.

Szasz and Hollender describe a pattern they term “mutual participation” and state that it is essentially foreign to the practice of medicine. As pointed out by these authors, philosophically, this model is predicated on the postulate that equality among human beings is desirable. Under this model, the Pphysician enables the patient to help him/herself and therefore the patient is a partner. This model is favoured by patients who, for various reasons, want to take care of themselves (at least in part).

## **1.4 RIGHTS OF PATIENTS**

### **1.4.1 Right to life**

The central tenet of the medical profession is the preservation of the life and health of patients.<sup>7</sup> The right to life is a basic human right from which other rights are derived. This right is intrinsic to the value we recognize in human life. Christians find an added value to human life as coming from God, the creator as a gift and consequently as being sacred. This right is guaranteed by article 12(1) of the Zambian Constitution which, provides that:

12(1) a person shall not be deprived of his life intentionally except in the execution of a court in respect of a criminal offence under the law in force in Zambia of which he has been convicted.

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<sup>7</sup> Sekelani Banda, Ed **A Handbook of Medical Ethics For Medical Students and Health Professionals** (Lusaka: Zambia Medical Association), 1998, p2

Therefore, in relation to the doctor-patient relationship, a Doctor must uphold a patient's right to life, by not intentionally taking away the life of his or her patient.

#### **1.4.2 The Right to Consent to Medical Procedures**

In the process of diagnosing or treatment of patients, it is inevitable for medical practitioners to make physical contact with their patients. In law however, an unintentional and unpermitted physical contact with another persons body by another, amounts to harm upon that person, which is referred to as a **battery**. For instance in the case of **Re MB**<sup>8</sup> the court of Appeal 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. However, doctors were entitled to administer an anesthetic to carry out birth by Caesarian section, where it was in the best interest of the woman and her child, given that she had a temporary lack of capacity because of panic brought on by fear of injection by needle. The law therefore protects a person from medical treatment he does not want even if others think he clearly needs it. For instance, Jehovah's Witness are a recognized religion. The tenets of the religion include a ban on the use of blood, blood products and human tissue. Most followers of religion carry a prohibitory card, which advises a doctor that even in an emergency that person would not accept the banned products. Therefore, even if a Physician clearly thinks that such a person needs blood and does not obtain consent, his rights would have been violated.

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<sup>8</sup> (1997) 147 NLJ 600

The term battery legally speaking is meant to cover acts of threats, force and physical trespassing against another person's body without proper consent from such person.<sup>9</sup>

Patients are given the right to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons. This is in line with the medico-moral principle of autonomy<sup>10</sup>. This refers to freedom on the part of the patient to determine ones own life, to act in accordance with ones own conscience and to control what is done to oneself. This means that before a particular course is undertaken, a patient has the right to consent to such a procedure.

Closely related to the issue of consent is the issue of mercy killing or what is technically referred to as Euthanasia. Euthanasia is the painless killing especially to relieve incurable suffering. It is also said to be "*the intentional termination of life by another at the explicit request of the person who dies.*"<sup>11</sup> It can also be on the judgment of the medical practitioner especially when his patient is in a vegetative state and there is no hope of recovery. This can be done by, for example: removing life support equipment like turning off a respirator or not delivering cardio-pulmonary resuscitation and allowing a person whose heart has stopped, to die. Euthanasia can also be active or passive. Active euthanasia occurs when treatment is administered with the intention of ending the patient's life. Passive euthanasia is when treatment to which the patient has not consented is ended. A landmark ruling came in the 1993 **Bland case.**

Anthony Bland was a 17-year-old boy, left severely brain damaged after the 1989 Hillsborough Football Stadium disaster. His parents and the hospital authority concerned

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<sup>9</sup> Stewart Page **Mental patients and the law** 1<sup>st</sup> Ed: (Vancouver: Self Counsel Press Limited) 1973, p51

<sup>10</sup> Supra note 7 at p35

<sup>11</sup> Jonathan Herring (2005) 4<sup>th</sup> Ed; **Criminal Law**; London: Palgrave Macmillan Publishers; p103

sought permission from the High Court to withdraw the artificial nutrition and hydration that was keeping him alive. The High Court and the House of Lords agreed.

If a person is suffering from a terminal illness and asks a doctor to help her die, what can the doctor lawfully do? If the doctor hastens the death of the patient, could he be convicted of murder? Two key questions are involved. First, did the doctor cause the death of the victim? Second, did the doctor intend to kill or seriously injure the victim? It is clear that the fundamental element of a crime, that is, the *mens rea* is absent.

A well-known example in the USA was the mercy killing in 1998 of a patient with ALS (Lou Gehrig's disease<sup>12</sup>) by Dr. Jack Kevorkian, a Michigan physician. His patient was frightened that the advancing disease would cause him to die a horrible death in the near future; he wanted a quick, painless exit from life. Dr. Kevorkian injected controlled substances into the patient, thus causing his death. Charged with First-degree murder, the jury found him guilty of Second-degree murder in 1999.

Other European countries do not allow euthanasia even if a patient wants to die - as a matter of public policy, the victim's consent does not provide a defence in the UK.

It is important to understand what constitutes valid consent. Depending on the circumstances, this may be given by means of a consent form, or inferred from the conduct of the patient. It can also be assumed if the patient is unconscious or otherwise unable to communicate. Consent can also be given by a patient's next of kin or by a

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<sup>12</sup>Lou Gehrig's disease refers to a disorder called amyotrophic lateral sclerosis. In the United States, ALS is often called Lou Gehrig's disease because of New York Yankees' star Lou Gehrig, who was diagnosed with ALS in the 1930s. This disease damages spinal cord pathways and motor neurons, which are important parts of the body's neuromuscular system

parent or guardian in the case of children and minors. It is also the primary duty of the Medical Practitioner to disclose the material risks and alternatives to the proposed procedures so that the patient can make an informed decision as to the best course of action.

### **1.4.3 Right to sufficient Information**

The patient must be informed about what is wrong and how the doctor hopes to help the patient. This must be done in the language that he or she understands. The information supplied to a patient must be easy for him/her to understand. Technical details are not normally grasped by the patient and may be out of the range of his experience. These, therefore, will not be termed as “informing”. It is aptly said:

Health care professionals should make sure that such information is truly comprehended. Comprehension means more than merely the ability to parrot facts. True understanding, in addition to an essential cognitive part, includes understanding on an emotional as well as, where possible, an experiential plane. It must include some understanding by the health care professional of what the diagnosis or condition means to patients: not just what it is scientifically, but what it connotes to and for patients: how it will be seen to impact on their daily lives and what it means emotionally for them, given their personal worldviews<sup>13</sup>.

The patient socially and legally is an autonomous individual and for him to make a rational decision of what should be done about his illness, he must be given all the information about his disease and the management thereof. This must include:

- (a) The modes of making a diagnosis
- (b) The diagnosis
- (c) The outcome of the disease if not treated

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<sup>13</sup> Sir Robert Hutchinson quoted in A.Ghosh, “**Whose Life Is It, Any Way?**” The Times of India (New Delhi) p.11 (Sept. 11, 2004)

- (d) The modalities of treatment and their outcome
- (e) The complication of treatment or diagnostic procedure
- (f) Finally, the patient's opinion, which in most cases is verbal but in certain cases consent, must be obtained in writing after the Patient or guardians have considered all the information.
- (g) Constant dialogue with the patient during his or her management<sup>14</sup>

It is important for the patient to be given such information so that he can make an informed decision as to whether to accept to undergo medical procedures or not.

#### **1.4.4 Right to Strict Confidentiality**

In a commonly used translation of the Hippocratic oath it reads: 'Whatever in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which applicant to be spoken of abroad, I will not divulge as reckoning that all be secret.'<sup>15</sup> The basis of the doctor-patient relationship is trust and confidentiality. Patients trust their doctors to protect their right to confidentiality. Over the ages, the doctor-patient relationship has been defined, through rules of ethics and rules of law, as a fiduciary one, a relationship founded on trust. When a patient seeks a Physician's help and the physician agrees to help, a special covenant is made. The patient agrees to take the physician into his or her confidence, to reveal to him even the most secret and intimate information related to his or her health. The physician in turn agrees to honour that trust, and to become the patients advocate in all matters related to his or her health, placing his interests above all others- including his own personal or financial concerns.

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<sup>14</sup> Supra Note 7 at P.15

<sup>15</sup> Yusuf Ahmed 'Confidentiality' in Sekelani Banda 'A handbook of Medical Ethics for medical Students and Health Practitioners' p.19

According to Yusuf Ahmed<sup>16</sup>, the need to keep confidential the information of their patients is termed 'professional secrecy' and the transgression of this secrecy can lead to a practitioner being found liable of 'infamous conduct. However, in certain circumstances the practitioner is obliged, (willingly or against his or her will) to disclose information regarding patients under their care, for example by the courts of law.

Closely related to the need to keep patients information in confidence is the right of patients to be treated in privacy. Patients have the right to be treated away from the public eye.

### **1.5 Patient's responsibilities**

1. Patients have the responsibility to provide accurate and complete information about current and past illnesses, medications and other matters pertaining to their health.
2. Patients have the responsibility to follow the treatment plan recommended by their medical practitioner or express concerns regarding their ability to comply.
3. Patients are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
4. Patients have the responsibility to arrive as scheduled for appointments and to cancel in advance appointments they cannot keep.

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. It is believed that health care professionals should treat patients as their friends, and not as

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<sup>16</sup> ibid

consumers of services. “The relationship between physicians and their patients emphasizes the peculiar mixture of detachment and involvement.

## CHAPTER TWO

### ELEMENTS OF NEGLIGENCE IN MEDICAL MALPRACTICE

Nowadays, professional negligence has been assuming an increasingly important role and in consequence, it has been receiving more and more attention. Lawyers, Physicians, Dentists, Hospitals, Accountants, Architects, Engineers, Real estate Brokers and Insurance Brokers, have all been involved in actions for professional negligence, with the result that the members of these professions as well as others have found it necessary to review their own positions in relation to their liability for negligence.

In chapter one, the medical profession in general, and the rights and responsibilities of the patient were discussed. It is therefore the purpose of this chapter to review the basis of professional negligence and how medical practitioners are held liable for negligence. It will also be imperative to distinguish between civil and criminal liability of negligence. The chapter will further consider the instances of medical negligence.

#### **2.1 Basis of professional Negligence**

Professionalism is characterized by several features. Professionals belong to an occupational group such as medicine, law, engineering, and teaching, which have a special body of knowledge that allows them to perceive things and understand problems of others better. Professionals go through a high level and advanced intensive training which provides them with a wide array of knowledge and skills enabling them to provide specific services. The knowledge they have is obtained from specialized schools.

Before we discuss the basis of professional negligence, it will be imperative to give a brief discussion on the law of negligence. Negligence was defined by Alderson B in the case of **Blyth v Birmingham Waterworks**<sup>17</sup> as:

*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.*

When considering negligence cause of action, there are four primary elements which need to be viewed and covered thoroughly: duty of care, breach of duty, causation, and resultant damage. Once this has been done, an appropriate award of damages may be considered.

A duty of care is a legal obligation imposed on an individual requiring that they exercise a reasonable standard of care while performing any acts that could foreseeably harm others.<sup>18</sup> For an action in negligence, there must be an identified duty of care in law. Duty of care may be considered as a formalisation of the implicit responsibilities held by an individual towards another individual within society. It is not a requirement that a duty of care be defined by law, but it will often evolve through the jurisprudence or common law. For instance in the case of **Donoghue v Stevenson**,<sup>19</sup> it was held that Manufacturers are responsible for adequately warning Consumers of possibly dangerous products. Failure to do so could make the manufacturer liable for possible damages.

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<sup>17</sup> (1856) 11 Ex 781

<sup>18</sup>R.A Percy **Charlesworth and Percy on Negligence** (1990) p50, Para 5-01

<sup>19</sup> (1932) A.C 532

Professionals are held to a higher standard of care than the average person in society. These people take oaths in their professions and need to maintain that level of duty when they perform their professional activities. Lord Atkins' statement in the case of **Donoghue V Stevenson**<sup>20</sup> about the foreseeability of the effects of one's acts on one's neighbours is central to the existence of a duty of care in the tort of negligence. In this judgment, he formulates what is commonly known as the "neighbour principle".

*The rule that you are to love your neighbour becomes in law you must not injure your neighbour; and the lawyer's question: Who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law, is my neighbour? The answer seems to be — persons who are so closely and directly affected by my acts 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.*

A patient can only recover compensation for loss which in law is not too remote. It used to be the law that, if a reasonable man would have foreseen that some damage might result from the wrongful act, the defendant was liable for all the direct consequences which in fact resulted, even though those particular consequences could not have been foreseen by anyone.<sup>21</sup> But now the defendant is liable only for damage which is of the same type as or of a similar type to the damage which could reasonably have been foreseen: he is not liable for damage which is of a different type from that which could reasonably have been foreseen.<sup>22</sup> In other words, the test is no longer subjective but objective.

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<sup>20</sup> ibid at p580

<sup>21</sup> Overseas Tankship (U.K.) Ltd. V Morts Dock & Engineering Co. Ltd (1961) A.C 388, P.C-The Wagon Mound II

<sup>22</sup> Re Polemis (1921) 3K.B 560, C.A.

Plaintiffs must have suffered damage - either physical, for example personal injury or economic that is, pure financial loss or both financial loss and personal injury - arising from the negligent act if they are to have a cause of action against the tortfeasor.

Professional negligence has been said to be an act or continuing conduct of a professional, which does not meet the standard of professional competence and results in provable damages to his/her client or patient.<sup>23</sup> Such conduct or omission may be through negligence, ignorance (when the professional should have known), or intentional wrongdoing. However, malpractice does not include the exercise of professional judgment even when the results are detrimental to the client or patient.

In 1832, Tindal C.J laid down the following rule in the case of **Lanphier v Phipps**<sup>24</sup>:

*Every person who enters into a learned profession undertakes to bring to it the exercise of a reasonable degree of care and skill; he does not undertake if he is an attorney that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure, nor does he undertake to use the highest possible skill. There may be persons who have a higher education and greater advantages and competent degree of skill and you will not say whether in this case the injury was occasioned by the want of such skill in the defendant. The question is whether this injury must be referred to the want of a proper degree of skill and care in the defendant or not.*

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 the like circumstances. When a doctor undertakes the management of a patient he owes his patient the duty of exercising due care, any reduction of which is technically a

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<sup>23</sup> G.Thomas, R. William, et al **Professional Negligence** (1960), P 5

<sup>24</sup> (1838) 8 C&P. 475

dereliction of this duty and may result in legal damage to the patient. In **Bolam v Friern**<sup>25</sup>, the necessary standard of care required of a doctor towards his patient was laid down to the effect that a doctor is not liable in negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of men and women skilled in the particular procedure. The High Court of Zambia in the case **Cicuto v Davidson and Oliver**<sup>26</sup> approved this proposition. This means that doctors could set their own standards of care between themselves and that it is not all acts or omissions of health care professionals that will amount to negligence. It does also not mean that a Doctor must always adhere to methods and practices that most of his colleagues employ. Deviation from normal practice is not necessarily evidence of negligence as there are certain acts, which will not merit a plea of negligence. In **Holland v Devitt and Moore National College**<sup>27</sup>, Streatfeild J. expressed the view that a doctor was entitled to use his common senses, experience and judgment in the treatment of each particular case, and a slight departure from the textbook would not of itself establish negligence.

## 2.2 **Definition of Medical Negligence**

As stated above, the essence of negligence is the failure to exercise due care and skill and the standard of care is that which one might expect a reasonably prudent person to exercise under like circumstances. Medical Malpractice is defined as the failure of a health care professional to exercise due and prudent care in order to avoid causing injury to patients they have the responsibility to care for.<sup>28</sup> Medical negligence generally suggests that the person that made the decision prescribed the medication or performed

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<sup>25</sup> (1957) 2 All ER 118

<sup>26</sup> (1968) Z.R 149 (H.C)

<sup>27</sup> The Times, March 4, 1960

<sup>28</sup> [www.medicalmalpractice.com/case-review.cfm](http://www.medicalmalpractice.com/case-review.cfm)

the procedure and made an error that could have reasonably been avoided. A doctor owes a duty of care to a patient, which, if breached will result in his liability. This was stated in the case of **Edna Nyasulu v Attorney General**<sup>29</sup>. The plaintiff in that case claimed damages for injuries sustained as a patient at U.T.H while under the care and attention of a qualified medical doctor. The claim arose out of the doctors' failure to administer tests or enquire orally as to whether the patient was allergic to Procaine penicillin. It was contended that the doctor had been negligent in not performing this standard procedure and thus was in breach of the duty of care owed to the patient.

### 2.3 **How does Liability Arise?**

In medical Malpractice cases, the patient alleges that the defendant (the health care professional) failed to provide the proper standard of care. The burden of proving negligence is on the person who alleges it, that is, the patient. He must prove on a balance of probabilities that the medical practitioners' negligence was the cause or one of the causes of the damage he has suffered. This task is not always easy but the patients' task has been made less difficult by the doctrine of *res ipsa loquitur*.<sup>30</sup> The doctrine is that 'where a thing is solely under the management of the defendant or his servants and the accident is such as, 'in the ordinary course of events, does not happen if those who have the management of such things use proper care,' the accident itself affords *prima facie* evidence of negligence.' For instance in the case of **Ndola Central Hospital v Alfred Kaluba and Priscilla Kaluba**<sup>31</sup> the Respondents sued for damages for negligence and nervous shock and stress arising from the disappearance of their newborn son from the Appellants' hospital. The Appellant had pleaded that the loss of the child by theft was

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<sup>29</sup> (1983) Z.R. 105 (H.C)

<sup>30</sup> The thing speaks for itself

<sup>31</sup> (1995-1997) Z.R 215 (S.C)

due to a criminal act beyond its control or contributory negligence on the part of the respondent for failing to secure the baby. The trial judge invoking the doctrine of *res ipsa loquitur* found the Appellant wholly to blame and awarded the sum of K40, 000,000 as damages. On appeal, the Supreme Court of Zambia held that the doctrine of *res ipsa loquitur* did not have to be specially pleaded. The trial judge could equally have grounded liability on the negligence that was pleaded, which had been established.

Doctors have several defences to malpractice actions, which include the doctrines of "accepted practice" and "error in judgment". According to Lord Denning in **Roe v Minister of Health** "In a professional man, an error of judgment is not negligent." If the doctor can establish that the actions which led to the injury were errors in judgment and not negligent, that the practice followed was accepted by other diligent and competent physicians and the injury merely an unfortunate result, or even that a minority of respectable doctors would act in a way which deviates from the standard accepted by most physicians, then the doctor may avoid liability unless negligence can be proven.

It is also trite that a patient will lose his remedy if he falls asleep on it. This means that a patient will not be entitled to recover damages if he does not file his claim on time. In Zambia, the Law Reform (Limitation of Actions) Act<sup>32</sup>, which follows the British Limitation of Actions Act, 1939, imposes a time limit of three years for bringing an action for personal injuries. This means that medical malpractice cases must be filed within three years of the occurrence of the mistake and not from the time of its discovery. Furthermore, the plaintiff must prove any one of those three elements, failure to which

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<sup>32</sup> Chapter 72 of the laws of Zambia

their action for damages will be dismissed. The Supreme Court of Zambia has stated that the plaintiff has a duty to adduce proper evidence of a medical nature if damages are to be awarded.<sup>33</sup>

#### 2.4 Criminal Liability in Medical Negligence

At Common Law, Criminal Negligence is not to be confused with negligence at tort. Criminal Negligence requires a greater standard of proof on those who wish to prove it, that is, the State. Criminal negligence is a criminal offence and to establish its existence the state must show beyond reasonable doubt that the accused was actuated in his negligence by deliberate and reckless disregard for the safety of the person concerned. As it was aptly stated in the case of **R v Adomako**,<sup>34</sup> the ordinary principles of the law of negligence apply to ascertain whether the defendant has been in breach of a duty of care towards the victim. In the case of **R v Bateman**<sup>35</sup> Hewart LCJ indicated that:

*In explaining to juries the test which they should apply to determine whether the negligence, in the particular case, amounted or did not amount to a crime, the judges have used many epithets such as "culpable", "criminal", "gross", "wicked", "clear", "complete". But whatever epithet is used and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment*

In Zambia, legislative provisions for imposing criminal liability in respect of negligence are set out in Sections 199 and 207 of the Penal Code.<sup>36</sup> Section 199 provides that:

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<sup>33</sup> Continental Restaurant and Casino Ltd v Arida Mercy Chulu SCZ judgment No. 28 of 2000 (unreported)

<sup>34</sup> (1994) 3All ER 79, H.L

<sup>35</sup> (1927) 19 Cr App R.8

<sup>36</sup> Chapter 87 of the Laws of Zambia

*Any person who by an unlawful act 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, whether such omission is or is not accompanied by an intention to cause death or bodily harm.*

And for purposes of causation Section 207 of the Penal code provides that:

A person is deemed to have caused the death of another person although his act is not the immediate or sole cause of death in any of the following cases:

- (a) If he inflicts bodily injury on another person in consequence of which that other person undergoes surgical or medical treatment which causes death. In this case it is immaterial whether the treatment was proper or mistaken, if it was employed in good faith and with common knowledge and skill; but the person inflicting the injury is not deemed to have caused the death if the treatment which was its immediate cause was not employed in good faith or was so employed without common knowledge or skill;
- (b) If he inflicts bodily injury on another which would not have caused death if the injured person had submitted to proper surgical or medical treatment or had observed proper precautions as to his mode of living;

## 2.5 **Instances of medical Negligence**

Medical negligence may take many different forms. Examples of these instances of medical negligence include: Failure to diagnose a condition, Wrong diagnosis, wrong medication, surgical errors, postoperative infections, dental malpractice and many more. Some of these instances will now be considered and explained.

### **2.5.1 Failure to diagnose a condition**

Failure to diagnose a condition can be considered medical malpractice depending on the circumstances of the patient's medical condition. By failing to recognize symptoms of certain conditions or failing to perform standard testing to screen for certain conditions, failure to diagnose serious health conditions will allow the patient to suffer irreversible health effects. Patients may have a high risk of developing certain conditions, thus doctors have a duty to provide adequate care and treatment to patients and the failure to diagnose a certain medical condition may amount to negligence. The commonest disease associated with the failure to diagnose is cancer. Due to the time sensitivity of the disease, the failure to diagnose cancer can result in death, in addition to extremely costly medical bills, pain and suffering.<sup>37</sup>

### **2.5.2 Wrong Diagnosis**

Wrong diagnosis of a medical condition can be a potentially serious type of medical malpractice that can result in serious injury or even death to a patient. Wrong diagnosis occurs when a person seeks medical advice from a Physician or any other health care Practitioner and is diagnosed with a condition that they do not have. Many conditions' symptoms are similar to the symptoms of other conditions, which can contribute to wrong diagnosis cases. In some wrong diagnosis cases, the patient may be suffering from a different condition and in others; the patient may not have a medical ailment at all.

There are a number of serious health conditions that are more frequently the subject of a wrong diagnosis. These include but are not limited to: Breast, prostate, cervical, Ovarian,

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<sup>37</sup> [www.medicalmalpractice.com/case-review.cfm](http://www.medicalmalpractice.com/case-review.cfm)

testicular and lung cancer, tuberculosis, diabetes, heart attack, strokes, pulmonary embolism, bacterial meningitis and appendicitis. A wrong diagnosis in addition to causing a serious misunderstanding of a person's condition can also result in wrong medication being administered, and failure to identify the true and potentially threatening condition at hand.<sup>38</sup>

### 2.5.3 Wrong Medication

Administering the wrong medication to a patient is one of the leading types of medical negligence that causes serious injury and illness. In the United Kingdom for instance, approximately 100,000 people were given the wrong medication from a medical professional in the year 2002 and 7000 people were killed because they were given the wrong medication.<sup>39</sup>

Wrong medication can be the result of many mistakes. The wrong medication altogether may be administered or improper dosage of the correct medicine may be prescribed. For instance if the proper dosage of Chloroquine is supposed to be two tablets after every two hours and the dosage prescribed by the doctor is four tablets after an hour, this in itself is negligence on the part of medical practitioner. The wrong medication may be given to a person with drug allergies or someone who is taking other medication that cause adverse reactions when combined, or someone with special health considerations<sup>40</sup>, that may be affected by this wrong medication.

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<sup>38</sup> *ibid*

<sup>39</sup> *ibid*

<sup>40</sup> For example liver and kidney problems

Nurses follow the “Five Rs” in medication administration as part of their standard of care responsibilities. These include:

- (i) The right medication
- (ii) The right patient
- (iii) The right dose
- (iv) The right route
- (v) At the right time.

These R’s must be adhered to so that a patient does not receive the wrong medication or medication that will injure or harm them in some way. If this standard is not adhered to and the wrong medication is given, thereby causing damage to the patient, the health care professional may be liable to damages in medical negligence.<sup>41</sup>

#### **2.5.4 Surgical Errors**

A surgical error can be directly responsible for causing a patient’s death or other serious complications. Common instances of surgical errors are preventable and largely attributed to a breakdown in communication between medical staff and patients. Examples of such errors include: performing the wrong surgical procedure, operating on the wrong body part and even the wrong patient and leaving surgical instruments within the patient’s body. For instance in the case of **Mahon v Osborne**<sup>42</sup> a Surgeon was held liable in negligence when he left a swab inside the body of his patient after a surgical operation. Another example of this kind of medical malpractice is amputation of the wrong body part.

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<sup>41</sup> ibid

<sup>42</sup> (1939) 2 KB 14

An 18 months old baby girl had part of her right hand amputated because of alleged professional negligence by University Teaching Hospital [UTH] medical personnel. Natasha Nakawala was amputated after she was taken to the hospital for treatment because she had pneumonia and diarrhoea. After being attended to, it was discovered that Natasha was dehydrated and that she be put on a drip to hydrate her. Drips of water were put on both hands until the following day. However, Natasha's father alleged that instead of inserting the syringe on the right arm into the vein, it was inserted in the flesh. It was discovered the following day that Natasha's right hand had swollen. After two weeks when the arm had started rotting and the skin falling off, Professor Kricor of the same hospital diagnosed Natasha with Gangrene [death of tissues] and recommended that the arm be amputated to stop other parts of the body from rotting.<sup>43</sup>

### 2.5.5 Hospital Malpractice

Hospital malpractice is inclusive of any type of medical malpractice occurring in a hospital. Instances of hospital malpractice can occur with any hospital staff, not just doctors. The law is that hospitals are liable vicariously for the negligence of the members of its staff, including the nurses, and doctors.<sup>44</sup> In the case of **Barnett v Chelsea and Kensington Hospital Management Committee**<sup>45</sup>, Mr. Barnett drank tea, which unknown to him had been contaminated with arsenic. He attended at the casualty department of a hospital saying that he had been vomiting for some three hours after drinking tea. The casualty doctor failed to examine him but sent a message that he should report to his own doctor. Some five hours later, Mr. Barnett died and on his widow's

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<sup>43</sup> The LRF News No. 32; October, 2001

<sup>44</sup> Cassidy v Ministry of Health (1951) 2.K.B 343

<sup>45</sup> (1968) 1All ER 1068

action for damages, it was held that the hospital authority owed him a duty of care and that the doctor was negligent in failing to examine and admit Mr. Barnett and accordingly there had been a breach of that duty. However, on the facts, the deceased's condition was such that he must have died despite any medical attention, which the hospital could have given so that causation was not established, and the widows' claim failed.

Similarly, a Medical Practitioner is liable for the negligence of an assistant or a *locum tenens*<sup>46</sup> employed by him but not for the negligence of nurses at a hospital when he does not employ them<sup>47</sup>. The amount of injury and financial loss experienced because of hospital malpractice can vary widely, ranging from death to bruises and cuts. All patients have rights and when a hospital malpractice has occurred they have a cause of action.

#### 2.5.6 Dental Malpractice

Like any other healthcare professional, a dentist is held to a certain standard of care when providing services to a patient. A breach of this duty might result in instances of dental malpractice or negligence. A possible dental malpractice claim can involve a wide range of improper treatment services rendered, or the failure to appropriately detect or diagnose conditions. Dental malpractice cases have included injuries to the jaw, lip and tongue nerves, anesthesia related injuries and deaths, the failure to detect or diagnose oral cancer and other oral diseases and injuries related to dental surgeries and treatments.

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<sup>46</sup> Temporal employment for Doctors

<sup>47</sup> R.A Percy (1990) Charlesworth & Percy on Negligence p607

### 2.5.7 Paralysis

*Paralysis is the term that describes an individual's loss of strength in a limb or muscle group. Caused by many different factors, paralysis can occur because of medical negligence. Depending on the extent of the injury, paralysis can affect an individual's mobility to a varying degree. When the legs have been completely or partially affected by paralysis, the patient is suffering from the type of paralysis called paraplegia. An even more severe instance of paralysis affects not just the legs but also arms completely or partially, called quadriplegia.*<sup>48</sup>

In the case of **Roe v Minister of Health**<sup>49</sup> two patients in a hospital had operations on the same day. Both operations were of a minor character and in each case nupercaine; a spinal anesthetic was injected by means of a lumbar puncture. The injections were given by a specialist anesthetist, assisted by the theatre staff of the hospital. The nupercaine had been contaminated in sealed glass ampoules, stored in a solution of Phenol, which had contaminated the nupercaine by penetrating almost invisible cracks in the ampoules. In that case, both patients became permanently paralysed from the waist down and they sued the defendants for negligence. The Court held that the defendants were vicariously liable for the negligence of those concerned with the operations. Paralysis can severely disrupt an individual's life, causing a large amount of pain and suffering, financial difficulties due to medical and loss of job abilities, emotional difficulties and loss of life's enjoyments.

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<sup>48</sup> Supra note 37

<sup>49</sup> (1954) 2 All ER 131

This chapter has endeavored to discuss negligence as a legal concept. It has also attempted to appreciate the concept of professional negligence with a bias towards medical negligence, which is the thrust of this paper. The next chapter will focus on the major factors that contribute to medical malpractice deaths and deformities in Zambia.

## **CHAPTER 3**

### **FACTORS THAT CONTRIBUTE TO MEDICAL MALPRACTICE, DEATHS AND DEFORMITIES IN ZAMBIA**

Providing health care is a difficult undertaking and it is inevitable for some level of mistakes to occur. When a medical mistake happens to a patient, the question is always why did it happen. In many cases, the issue is not one of negligence by a doctor or other medical practitioner, but rather a systemic issue. On the other hand, there are many cases of malpractice brought against medical practitioners, alleging various levels of failings. This chapter shall attempt to categorize some of the possible causes of medical malpractice or errors. This will be looked at from three perspectives: General medical industry problems individual doctor mistakes and patient mistakes.

#### **3.1 GENERAL MEDICAL INDUSTRY PROBLEMS**

Although some errors are unavoidable, medical practitioners and the medical industry in general could do much better. It is important to discuss the various problems experienced by medical doctors and the medical industry, for not all deaths or deformities should be attributed to medical malpractice of medical practitioners.

The University Teaching Hospital (U.T.H), which is Zambia's largest referral hospital, has in the recent past suffered from a number of serious problems, which have largely affected its operations. These problems range from shortage of drugs and medical equipment, to brain drain and other administrative problems. These problems affect the

smooth running of the hospital and thus contribute to a considerable extent to most of the deaths and disabilities.

### **3.1.1 Shortage of medical personnel**

One of the problems being experienced by the medical industry is the shortage of medical personnel. According to a survey conducted at the U.T.H, the hospital has been operating with very few medical personnel after a spate of resignations by doctors and other medical practitioners. The medical industry has been the worst hit by the problem of the brain drain. The flight of doctors and nurses from countries in sub-Saharan Africa is a serious problem. According to **Inter press Service News Agency**, “the situation is perhaps most dramatically illustrated in Zambia. Only 50 of the 600 Physicians trained in the country’s medical school between 1978 and 1999 are working in the nation. A few years ago, Zambia had 1,600 medical doctors. Today, Zambia has only 400 medical doctors.”

The question to be asked is where are the medical professionals going? Some are going to nearby Botswana. But the preponderance is going to the United States of America, the United Kingdom and Australia. A recent report revealed that in 2002-3; almost half of the new nurses registered to work in Britain were from abroad, making the UK the biggest recruiter of nursing staff.<sup>50</sup>

Another question to be asked is why are the medical practitioners leaving? Honestly, you can hardly blame them. The conditions of service for doctors in Zambia are horrendous.

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<sup>50</sup> News.Scotsman.com

There are both “push” and “pull” factors. “Push” factors include low pay and poor working conditions. Pull factors are equally or more important. Poor working conditions and meager salaries are seen as the main push factors behind the country's medical brain drain. One of the “pull” factors is that the countries where these professionals are going offer better working conditions and attractive wages and salaries.

According to an interview the editor of JCTR Bulletin<sup>51</sup> had with six doctors who have been serving the health sector in Zambia for a total of 31 years, one of the major push factors is accommodation. Some doctors do not even have official accommodation. Those who have been accommodated are evicted now and again because the government does not pay the rentals. At UTH, 30 doctors share four common toilets and one bathroom in an intern's block. They have one room each in the block which some of them share with their wives and children. It is obvious that the dismissal of the junior doctors, rather than resolving the matter amicably, is tantamount to imposing death sentence on the sick and those currently in hospitals.

Catherine Zimba, a Zambian nurse working in the United Kingdom told IRIN<sup>52</sup>: "Nurses come here primarily for money. Here we are respected - but back home, when people see a nurse, they see poverty." Zimba worked as a psychiatric nurse in Zambia's public health system for 12 years before leaving for Britain in 2002. "In hospitals back home we run out of drugs, equipment and simple IV (intravenous) fluids," she added. Zimba said there were also greater opportunities for further training in the UK. "Here we are encouraged by our employers to study, but back home it is a struggle; in Zambia, the same people

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<sup>51</sup> JCTR Bulletin Number 43 2000

<sup>52</sup>[www.IRIN.org](http://www.IRIN.org)- “Integrated regional information Networks”

attend workshops - here they advertise these things and it is up to an individual to apply."

Erick Ndhlovu, a male nurse working in Britain, said the financial reward has been worth the move. "You can't blame anybody who leaves the country because the money is so meagre, that one cannot even dream of buying property, or providing a decent quality life for the family. The morale at work didn't help, because a patient would die in your care because of the lack of basic facilities," he commented.

The critical shortage of medical staff in Zambia is compromising the quality of public health care as doctors and nurses continue to leave the country in search of more lucrative employment. One consequence of the exodus of medical personnel is that nurses and doctors who remain in Zambia have their workload doubled. They are usually frustrated, over-busy and over-tired from excessive time schedules and too much work or patients to attend to. A recent study by the UN Population Fund found that at the UTH, only one nurse is assigned to each ward.

The other effect of the problem of shortage of manpower is that unqualified personnel sometimes attend to patients. At the UTH, patients are sometimes attended to by medical assistants and the general staff even for serious cases. When these persons on whom these duties have been delegated default, the medical practitioner who delegated or the hospital authorities are held vicariously liable for the negligence of such unqualified personnel.

### **3.1.2 Shortage of medical Equipment**

Another problem facing the medical industry is the shortage of medical equipment and the slow adoption of new technologies. A survey conducted at the UTH revealed that

most of the equipment was either archaic or not in proper working condition. There are insufficient basic equipments, like, suction machines, incubators, BP machines, thermometers, simple antenatal urine test machines, slides for malarial tests, and many others. The same applies to the supply of running water and oxygen. For instance, there is no running water at the University Teaching Hospital (UTH) after 19:00 Hours.<sup>53</sup> These are basic things, which must be available in hospitals at all times, and some of these are not costly. Some of the deformities and deaths that result would be avoided had the medical practitioner used the proper medical equipment, capable of detecting different organs in the human anatomy.

### **3.1.3 Shortage of Drugs**

Health care conditions now are very harmful because even when a doctor makes a correct diagnosis the drugs are not available. It is regrettable to note that there have been several cases of people who have died when their lives could have been saved. Zambia has been no exception to the problem of shortage of drugs, being faced by most sub-Saharan African countries. Many are the times when patients are given prescriptions with which to procure drugs. With the current economic conditions prevailing in the country, it is not possible for all Zambians to procure the prescribed drugs. The hospitals the Zambian doctors work in are so rundown that the doctors helplessly watch some of their patient's die of minor diseases because the government has failed to provide basic life-saving facilities such as IV fluids or oxygen. Even surgical gloves and painkillers are rare and hospital pharmacies are dry. Hospitals and clinics have become places where patients go to see medical personnel, who will only assist them by giving them a prescription. It has

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<sup>53</sup> JCTR Bulletin Number 43 First Quarter 2000

become apparent that quality health care in Zambia has become something that is only enjoyed by people who can afford it.

#### **3.1.4 Overcrowding in Hospitals**

Another problem faced by the health industry is the problem of overcrowding. Being the largest referral hospital, the UTH suffers from the problem of overcrowding. Many factors contribute to overcrowding, including inadequate or inflexible nurse-to-patient staffing ratios, isolation precautions, or delays in cleaning rooms after patient discharge; an over reliance on intensive care or telemetry beds; inefficient diagnostic and ancillary services on inpatient units; and delays in discharging hospitalized patients to post acute-care facilities. In some of the hospitals in Zambia, patients with tuberculosis are made to share the same wards with patients suffering from non-infectious diseases such as malaria.

Hospital overcrowding presents a challenge for hospital employees and clients, often leading to frustration and dissatisfaction. Overcrowding also has a direct effect on patient care, including compromised patient safety, increased costs, increased length of stay, and increased mortality and morbidity rates. The emergency or Casualty department has been changed from a temporary holding area to an extended patient care unit, decreasing its ability to handle new admissions and to manage a mass casualty. Beds in the critical care or Intensive care units become filled with inappropriate patients if floor beds are not available, making placement of seriously ill patients difficult. Therefore, critically ill patients will be attended to when it is too late or they would have already died from hemorrhage.

### **3.2 INDIVIDUAL ATTITUDE AND MISTAKES BY MEDICAL PERSONNEL**

It is common knowledge that everyone makes mistakes, even the best doctors. However, the attitude of some medical health personnel leaves much to be desired. Health Care Workers are key players in the prevention and management of diseases. Their perceptions, attitudes and practices have implications for the management of diseases. The practice of medicine is a service; therefore, at all times certain qualities are required of the physician- readiness to help, knowledge concerning the nature of disease, and skill in curing the sick man. Some patients allege that some working doctors, nurses and other staff do not pay attention to them. Others complain about being shouted at and being neglected by medical personnel.

One such case is of Silver Sinkoyo, whose child had a deep wound which a nurse inflicted on him. Narrating the ordeal, Sinkoyo said on February 22, 2005 her child was sick and taken to Mandevu Clinic for treatment. She said from February 22 to February 28 her child was being injected on the same place in the skin and not in the vein. "When I took my child for review, I noticed that the part where my child was being injected was swollen. I told the doctor to check on the child, which she did, and referred me to the University Teaching Hospital for an operation," she said. She said on March 10, Sinkoyo went to UTH where the child was operated on successfully. The woman said after the operation, the wound became bigger and Sinkoyo went back to the clinic, but she alleged that she was shouted at by the same nurse that had attended to her and was told to go back after four days. "When I went back to the clinic, the nurse was called by the sister-in-charge and was questioned about the incident and she accepted having made a mistake.

"When asked whether the nurse would clean the wound of the child, the nurse did not show any interest", she said. The woman got angry and approached Legal Resources Foundation for help. She said she wanted to sue the nurse for professional negligence.<sup>54</sup>

Other mistakes by medical practitioners may include: Poor handwriting, which can lead to errors in filling in prescriptions or wrong hospital medications or tests; Poor dosage instructions; which may be difficult to read such as zeroes and decimal points can lead to wrong dosages. Other mistakes made by medical practitioners include pathology laboratory mistakes, where various laboratory tests used for diagnosis and sometimes treatment planning can have several types of errors. These include cross-contamination during testing limitations of certain tests for certain patients.

### **3.3 PATIENT MISTAKES**

The patient can contribute a great deal to an error occurring in their health care. Patients should view achieving good medical care as something over which they have partial control. It is trite that in law, a plaintiff's proximate contributory negligence will bar recovery completely. For instance, failure to report symptoms for various reasons such as embarrassment or thinking that it will be irrelevant or delays in reporting symptoms may lead to errors in their treatment. Other mistakes include failure to report other medications they are on, either prescription or over-the-counter medications, and failure to report other alternative medicines they are taking. Non-compliance with the treatment plan or medications and dishonesty of patients due to the desire to obtain certain restricted drugs, are also some of the instances of patient mistakes.

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<sup>54</sup> The Legal Resource Foundation News, May 2005

From the above outline, it can be stated that there are several factors that contribute to negligence, deaths and deformities in hospitals. These factors range from general medical industry problems, individual mistakes by medical practitioners and patient mistakes.

In chapter four, the writer will give an analysis of the extent to which the Zambian Judiciary and the legislature have appreciated and responded to claims of medical negligence. This will be compared with the amount of attention that has been given to medical negligence by other countries such as the United Kingdom and the United States of America.

## CHAPTER FOUR

### JUDICIAL AND LEGISLATIVE RESPONSE TO MEDICAL NEGLIGENCE

Medical negligence is not different from any other type of negligence. Doctors and other learned professionals - including architects, lawyers, and accountants - have been singled out from other occupations in their professional liability to clients. The traditional basis for professional liability is negligence. 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. Thus, in principle, the law of medical negligence holds health-care providers liable only for medically caused injuries that are caused by negligence. By imposing sanctions on Medical practitioners found negligent, this deters future negligent behaviour.

In this chapter therefore, the emphasis will be on how the courts have responded to medical negligence claims and what legislation has been put in place to avert the problem of medical negligence. This will be compared with the approach of the courts in other jurisdictions.

#### 4.1 Judicial Response to Medical Negligence in Zambia

There have not been so many cases before Zambian courts pertaining to medical negligence. Despite the numerous complaints by people about medical practitioners being negligent, very few cases have actually reached the Zambian Courts. Some people simply ignore it, while others consider it as something that is normal and part of their lives. There is a common saying that a 'persons' death is the wish of God'. While this is true,

some deaths or deformities could have been avoided, had the proper precautions been taken. Most Zambians are financially incapacitated to commence lawsuits against negligent doctors, while the majority of patients who have had the chance of instituting legal proceedings against negligent medical practitioners prefer to settle the matter out of court.

The duty of care that has been applied in negligence cases, whether, the ordinary negligence or professional negligence is the neighbour principle enunciated by Lord Atkin in the case of Donoghue v Stevenson. This was followed in the cases of Michael Sata v Zambia Bottlers<sup>55</sup> and the case of 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 evidential proof thereof, on a balance of probabilities.

The Zambian Judiciary in the case of Cicuto v Davidson and Oliver has applied the 'Bolam principle' enunciated in the case of Bolam v Friern<sup>56</sup>, in relation to the standard of care required of medical practitioners. This principle was that:

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

However, since the case of Cicuto v Davidson, there has never been any case in relation to the standard of care required of medical Practitioners. Therefore the standard means that a practice is right if a body of respectable and responsible men under the same

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<sup>55</sup> SCZ No. 1 of 2001

<sup>56</sup> [1957] 1WLR 583,587

circumstances is following a particular procedure in similar conditions. The result of this is that medical practitioners would hide behind the guise of "accepted practice" in order to escape liability. This would mean that even what a medical practitioner has done is negligent on the face of it, the medical practitioner would not be held liable in negligence if he can prove that what he did was in accordance with a procedure accepted as proper by other medical men. It is clear that the Zambian Courts have not been inclined to hold medical Practitioners liable for negligence.

#### **4.2 Legislative response to medical Negligence in Zambia**

There is no specific statute in Zambia that deals with medical negligence of medical practitioners. However, there are some statutes, which although they do not talk about medical negligence explicitly, they impliedly consider the question of medical negligence.

Section 199 of the Penal Code provides that:

Any person who by an unlawful act or omission causes the death of another person is guilty of the felony termed "man-slaughter". An unlawful omission is an omission amounting to 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.

Section 207 of the Penal Code provides that:

A person is deemed to have caused the death of another person although his act is not the immediate or sole cause of death in any of the following cases:

- (a) If he inflicts bodily injury on another person in consequence of which that other person undergoes surgical or medical treatment which causes death. In this case it is immaterial whether the treatment was proper or mistaken, if it was employed in good faith and with common knowledge and skill; but the person inflicting the injury is not deemed to have caused the death if the treatment which was its immediate cause was not employed in good faith or was so employed without common knowledge or skill;
- (b) If he inflicts bodily injury on another which would not have caused death if the injured person had submitted to proper surgical or medical treatment or had observed proper precautions as to his mode of living;

The duty of care is provided for by section 210 of the Penal Code which provides that: It is the duty of every person having charge of another who is unable by reason of age, sickness, unsoundness of mind, detention or any other cause to withdraw himself from such charge, and who is unable to provide himself with the necessaries of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries 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.

In relation to Section 210 of the penal Code, a medical practitioner would be held criminally liable for negligence, if he fails to exercise care towards the patients who are under his care.

Section 55(1) of the Medical and Allied Professionals Act 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:

- (a) direct the erasure of his name from the register;
- (b) censure him;
- (c) 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;
- (c) order him to pay to the Council any costs of and incidental to the proceedings incurred by the Council.

This also sated in section 27(1) of Nurses and Midwives Act.<sup>57</sup> These statutes do not however define what is or what constitutes infamous conduct. Other authorities and the medical Council of Zambia have adopted a more comprehensive meaning to infamous conduct. They include other ethical matters such as advertising, canvassing, fee splitting, granting a certificate of illness without personal verification, abusing the dignity or privacy of the patient, personal misuse of alcohol, failure to report professional misconduct of a colleague, and forgery.<sup>58</sup> However, case law has come to the aid of this. For instance, in the case of Easson v L.N.E<sup>59</sup>, infamous conduct was defined to mean no more than serious misconduct judged according to the rules written or unwritten, governing the profession. Even then, this is not very helpful as there are no laid rules that govern the medical profession in Zambia.<sup>60</sup>

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<sup>57</sup> Chapter 300 of the Laws of Zambia

<sup>58</sup> Sekelani Banda, supra note 7 at p117

<sup>59</sup> (1944) 2 K.B. 421

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### 4.3 Judicial and legislative Response to Medical Negligence in other countries

There have been numerous legislative changes in other countries, including an overhaul of health care and civil liability law. Over the last two decades most states in the US have enacted some tort reforms for medical malpractice. There has also been reform on the law relating to medical negligence in other countries.

It is accepted that when one is an actual patient, the medical practitioner treating him owes him a duty of care. The English Courts have slowly been moving away from the Principle established in the **Bolam** case. The **Bolam** case was cited, for instance to justify an action against a Surgeon who failed to warn a patient that an operation to treat rectal prolapse might mean that the 28 year old man would be unable to have sexual intercourse. The fact that the case was won for the plaintiff, arguably by such misappropriated case law, did little to establish patients' rights on a more secure footing.<sup>61</sup> This case can be one of the very rare cases in which a doctor had been held liable in negligence even though acting in accordance with a practice accepted as proper by other competent colleagues.<sup>62</sup>

There is a new developing jurisprudence in this area, which is more testing of clinicians than previously was the case. The judge at trial will assess what a responsible body of medical opinion is by listening to the medical experts on each side. In **Bolitho v City and Hackney Health Authority**<sup>63</sup>, the House of Lords held that where the body of expert opinion cannot be logically supported, the judge can reject the evidence on the grounds that it is not reasonable.

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<sup>61</sup> Smith v. Tunbridge Wells Health Authority [1994] 5 Med L.R.334

<sup>62</sup> Keown J., "Easing the burdens on medical plaintiffs" Cambridge Law Journal 1995; 54(1): 30-32, pp.30-32

<sup>63</sup> [1998] Lloyd's Rep Med 26

There are many ways to treat patients and any court would look to experts in the medical or nursing professions to help them assess whether the clinical guideline used in the case was proper or not. The views of experts are however not definitive; they may show that a reasonable body of medical opinion may have designed and used a clinical guideline in a certain way, but the judge in the case will have the final say. This means that unlike the Zambian Courts, the English courts will have to assess the credibility of the body of medical men and to find out if the procedure accepted as proper is reasonable.

In the United Kingdom, the courts have gone further to venture in other areas one would not expect the Zambian Courts to look into. For instance, the Courts have held that doctors will be held to have been negligent in admitting patients in the same ward with patients suffering from infectious diseases. In the case of Heafield v Crane,<sup>64</sup> a pregnant patient was admitted to hospital for her confinement and was placed in the same ward with a woman suspected of suffering from puerperal fever<sup>65</sup>, as a result of which she too became infected. The doctor was held to have been negligent in not isolating her and in failing to take steps to prevent her from becoming infected.

There have been major tort restrictions enacted by states in the USA, each of which takes away the rights of patients injured by medical negligence, makes it more difficult for them to obtain fair compensation, and makes it harder to hold accountable those responsible. No profession in the USA currently has more legal protection for their negligence than the medical profession.<sup>66</sup> For instance the medical malpractice Act of the

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<sup>64</sup> (1937) The Times July 31,

<sup>65</sup> Fever that lasts for more than 24 hours within the first 10 days after a woman has had a baby.  
<http://www.medterms.com>

<sup>66</sup> <http://www.centerjd.org/free/medmallist.htm>

State of Virginia excludes the right to sue for children injured at birth. In the State of Oregon punitive damages were abolished against doctors by the Medical malpractice Act.

In New South Wales, the law gives protection to medical practitioners from liability for treatments without consent in various emergency situations. For example, section 55 to 58 of the *Civil Liability Act 2002* of New South Wales protects “good Samaritans” (which may include medical practitioners) from any kind of personal civil liability for any act or omission in an emergency when assisting an apparently injured person or a person at risk of being injured.<sup>67</sup>

#### **4.4 The role of the medical Council of Zambia**

This body, which was created under section 3 of the Medical and Allied Professions Act, issues practicing licenses and is also supposed to regulate medical practice by ensuring discipline of all registered medical practitioners, inspect medical facilities, that is, physical infrastructures in the hospitals, equipments, recommend improvement of the medical facilities, and close down hospitals if they prove to be below the required standard. In spite of the excessive deplorable conditions in the public hospitals, Medical Council of Zambia has never closed down a public hospital, but has never hesitated to close down private hospitals.

In this chapter, we have discussed the judicial and legislative response to medical negligence in Zambia. We also discussed the response of the Judicial and legislatures in other country to medical negligence. It was discovered, that there have not been so many cases on medical negligence before the Zambian Courts, as compared to the number of

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<sup>67</sup> [www.lawlink.nsw.gov.au](http://www.lawlink.nsw.gov.au)

incidents on medical negligence. The approach taken by the courts has been too lenient towards negligent medical practitioners. In terms of legislation, there is no single statute that deals with medical negligence. There are however other statutes that deal with medical negligence indirectly.

## CHAPTER FIVE

### CONCLUSION AND RECOMMENDATIONS

#### 5.1 Conclusion

This study has ventured to assess the law on professional negligence and specifically medical negligence in Zambia. It has discussed the doctor-patient relationship and the duties of the Doctor on the one hand, and the rights and responsibilities of the patient on the other hand. It has also discussed the law of negligence in relation to professionals, that is the duty of care and the standard of care required of professionals.

It was found in this study that there are a number of factors that contribute to negligence, deaths and deformities in Zambian Hospitals. These factors range from general medical industry problems, attitude of medical personnel and patient mistakes. Among these factors include: shortage of medical personnel, shortage of drugs and medical equipment, individual attitude of doctors and other medical personnel. Problems of insufficient resources are often cited to justify the deplorable conditions of our hospitals. But at the same time, very little resources are allocated to the Health sector.

We also assessed the level of judicial and legislative response to medical negligence in Zambia. It was found that on the overall, there have been very few cases of medical negligence before the Zambian Courts. This is not to say that there have been very few incidences of medical negligence, but that very few cases in fact reach the courts. This is largely attributed to the financial incapacity of most Zambians and the fact that most victims of medical negligence are not aware of their rights. Of the few cases on medical negligence that the courts have had occasion to adjudicate, the courts have been more

inclined towards giving immunity to medical practitioners. People are losing faith in the judicial system and the result has been lack of litigation of medical negligence issues.

There is very limited legislation on medical negligence. Some of the statutes do not expressly mention medical negligence. There is no single statute devoted to professional negligence or medical negligence.

The medical Council of Zambia, which regulates the practice of medicine and the conduct of medical practitioners, is also another institution where medical negligence cases can be reported.

## **5.2 Recommendations**

Overall this study establishes that medical negligence is rife in Zambia. The study has led to the following recommendations:

1. The Government should put up legislation that deals with Professional negligence in general or specifically medical Negligence.
2. The Medical and Allied Professions Act and the Nurses and Midwives Act should be amended to define or to lay down what constitutes “infamous conduct”. It is not possible to compile a list of all the matters that constitute “infamous conduct”. However, it is recommended that this definition or list of matters that constitute infamous conduct should not be exhaustive, but should be inclusive to allow for more things to be added. It is important to codify this because where there are no adequate guidelines there can be arbitrariness.

3. The Ministry of Health should also carry out a survey of the number of hospitals, Clinics or Surgeries operating, to find out if registered medical personnel are operating these. This is because only registered medical practitioners can be disciplined for 'infamous conduct' and hence by doing so, the net for infamous conduct will be made wider.
4. There is need to sensitize the public and specifically the patients on the law of medical negligence. The Ministry of Health can come up with a Charter on patients' rights and responsibilities and made available to all hospitals, clinics and Surgeries. This Charter should be put in a conspicuous place, so that patients are made aware of their rights and duties.
5. Patients should be encouraged to settle their disputes through alternative dispute Resolution mechanisms such as Arbitration or Mediation, which are cheaper and flexibility. This would discourage litigation, which is what Zambia needs given the huge backlog of cases in the Courts.
6. Medical Practitioners like Accountants and Lawyers should be accountable. The Ministry of Health through the Medical Council of Zambia, which is the regulating body in the practice of medicine, should make medical practitioners more accountable. They should create a disciplinary process that inspires confidence and is fair and accountable to patients, physicians, and general public.
7. The Minister of health recently announced that to avert the problem of medical brain drain, they would increase intake into the School of Medicine. However, even if they increase the intake of students into the school of medicine, the problem of Medical Practitioners leaving the country will not be solved, if the

conditions of service for medical practitioners are not improved. It goes without saying that a decent and internationally competitive salary for all health workers in government service is a strong instrument in retaining staff. However, given the constraints the Government is facing, this is not likely to be realized on a short term. It does not however mean that the salaries that should be given to medical Practitioners in Zambia should match up to the standards of salaries in developed countries like the USA and the UK, where the preponderance of the medical practitioners are going. However, a decent salary that matches up with ones qualification and experience is feasible. For instance, the Zambian government can increase funding to the Health sector and reduce funding to areas which do not need immediate attention. For example they could reduce funding to the Cabinet for procurement of motor vehicles for Ministers. They should prioritize the health sector in budgetary allocations because this industry affects each and every person in Zambia.

8. Retention schemes are intermediate second-best solutions to the problem of brain drain. Decent human resources management, which acknowledges the efforts of people and respects their human dignity, is already an important first step in retention. When people get their appointment in time, their confirmation in time, be put on the pay role without delay, get appraised regularly and get promotion when due, get their leave benefits when entitled, already many people feel more satisfied as employee. When a career development is offered, without favoritism or corruption, commitment to the organization is created. These measures do not need big investments, only competent and committed managers and human

resource officers. This will not only change the attitude of medical Practitioners, but also make them more enthusiastic.

9. To avert the problem of overcrowding in most of Zambia's major hospitals, it submitted that government should enforce strictly the Health Reforms of 1992. Under the health reforms of 1992, clinics were supposed to be upgraded with the idea of using hospitals as referral centers only.<sup>68</sup>Hospitals should deal with more serious cases, which are beyond the scope of the clinics. Another alternative is to upgrade some clinics into hospitals.

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<sup>68</sup> Central Board of Health, Action Planning Handbook 1st level referral Hospital 2nd Ed. 2001, Central Board of Health: Lusaka.

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