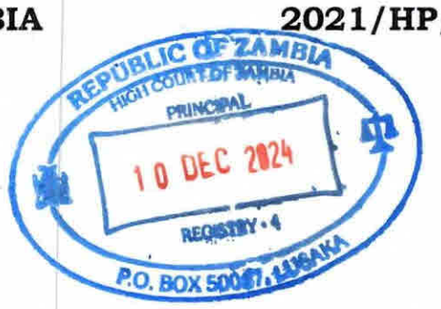
IN THE HIGH COURT FOR ZAMBIA **2021/HP/0790**
AT THE PRINCIPAL REGISTRY
HOLDE AT LUSAKA
(Civil Jurisdiction)



BETWEEN

JAMES PHILLIP MDALA *(Suing as Administrator of the Estate of Agnes Lucia Kaluzi Mdala)* **PLAINTIFF**

AND

VIVA MED LIMITED	**1ST DEFENDANT**
DR. AKHTA AKHTAEV *(Medical Practitioner)*	**2ND DEFENDANT**
DR. DILDORA KAJIMATOVA *(Medical Practitioner)*	**3RD DEFENDANT**
NASRIN PATEL *(Nurse Practitioner)*	**4TH DEFENDANT**
LINNAH CHIBWE *(Nurse Practitioner)*	**5TH DEFENDANT**
HEALTH PROFESSION COUNCIL OF ZAMBIA	**6TH DEFENDANT**

Before: ***The Honourable Mr. Justice C. Zulu***

For the Plaintiff:	Mr. M. Ndalameta & Ms. C.L. Sinkala, Messrs Musa Dudhia & Company.
For the 1st to 5th Defendants:	Mr. S. Bwalya and Mr. S. Limbada, Messrs Solly Patel, Hamir & Lawrence.
The 6th Defendant:	Mr. M. Chanda, Messrs Equitas Legal Practitioners.

J U D G M E N T

Cases referred to:

1. ***Bolam Friern Hospital Management Committee [1957] 1 WLR 582.***
2. ***Chester v Afsher [2002]3 All ER 552 CA at 554, 560 and 561.***

3. ***Ndola Central Hospital Board of Management v Alfred Kaluba (SCZ Judgment No. 9 of 1997).***
4. ***X and Ors (Minors) v Bedfordshre CC, M (a minor) v Newham London BC, E (a minor) v Dorset [1995] 3 All E.R. 353, HL.***
5. ***Re Wagon Mound (1961) 1 All ER 404.***
6. ***Nyimba Investments Limited v Nico Insurance Zambia Limited (SCZ Selected Judgment No. 12 of 2017).***
7. ***Roe v Ministry of Health [1954] 2 All ER 131.***
8. ***Parker v Parker [1957] 2 All ER 127.***
9. ***Edna Nyasalu v Attorney-General (1983) Z.R. 105 (H.C.).***
10. ***Rosemary Bwalya v Zambia Consolidated Copper Mines Limited (Mufulira Division) Malcolm Watson Hospital and Dr. Y.C. Malik (2005) Z.R. 1.***
11. ***Buls v Tsatsarolakis (1976) (2) SA 891 (T), at page 893-894.***
12. ***Castel v De Greef (1994) (40) SA 408.***
13. ***Nyali v the Attorney General (1956) 1 QB 1 at page 16-17).***
14. ***Match Corporation Limited v. Development Bank of Zambia and Another (S.C.Z. Judgment No. 3 of 1999).***
15. ***Fawaz and Chelelwa v the People (1995-1997) Z.R. 3.***
16. ***Attorney General v Rosemary Mulenga (SCZ No. 52 of 2014).***
17. ***Attorney General v Mwanza and Another (selected Judgment No. 38 of 2017).***

Legislations and other materials referred to:

1. ***Health Professions Act No. 24 of 2009.***
2. ***Health Professions (Disciplinary Proceedings) Rules, Statutory Instrument No. 114 of 2013.***
3. ***Contempt of Court (Miscellaneous Provisions) Act, Chapter 38 of the Laws of Zambia.***
4. Margret Brazier and Emma Cave, ***Medicine, Patients and the Law 4th Edition*** (Nexis Lexis: Butterworths, 2007) at page 156.

1.0 INTRODUCTION

1.1 The Plaintiff, James Phillip Mdala, in a representative capacity, as the administrator of the estate of his late wife, Agnes Lucia Kaluzi Mdala, took out the present action dated July 12, 2021 against the above named Defendants. The Plaintiff is generally seeking damages for medical negligence against the First Defendant, Viva Med Limited, and its health practitioners, the Second to the Fifth Defendants for negligently causing the death of his wife, who died on December 23, 2020.

1.2 The deceased was admitted to Viva Med Hospital, on December 18, 2020 for removal of a lump detected in her breast, otherwise the operation is called lumpectomy in medical parlance. And the reliefs sought by the Plaintiff in this action are:

i. damages for negligence by the 1st Defendant;
ii. damages for negligence by the 2nd Defendant;
iii. damages for negligence against the 3rd Defendant;
iv. damages for negligence by the 4th Defendant;
v. damages for negligence by the 5th Defendant;
vi. damages for breach of statutory duty by the 6th Defendant;
vii. a declaration that the 1st Defendant as a private health facility cannot hold a Class A licence for as long as it is not equipped with a functional Intensive Care Unit.
viii. a declaration that the 1st Defendant as a private health facility cannot conduct operations and procedures under general anaesthesia for as long as it is not equipped to deal with the complications that arise under general anaesthesia;
ix. a mandatory injunction requiring the 6th Defendant to enforce the declaration referred to in paragraphs (vii) and (viii) above;

x. ***aggravated damages from the first Defendant;***
xi. ***aggravated damages against the 2nd Defendant;***
xii. ***aggravated damages from the 3rd Defendant;***
xiii. ***aggravated damages from the 4th Defendant;***
xiv. ***aggravated damages from the 5th Defendant;***
xv. ***interest on any and all damages awarded***
xvi. ***further or other relief; and***
xvii. ***costs for and incidental to this action.***

1.3 The particulars of negligence were respectively outlined against the First to the Fifth Defendants as follows:

1. ***The 1st and 2nd Defendants did not warn the deceased about any risks of surgery, let alone the possibility of the operation being fatal.***
2. ***The lumpectomy was an elective surgery.***
3. ***The 1st and 2nd Defendants did not follow the breast cancer screening and diagnosis guidelines which dictate that after an ultrasound and mamography as the initial investigation, a core needle biopsy should be done. The results from the core needle biopsy would dictate the next step of management.***
5. ***Altering the section on known allergies by deliberately shading and hiding what was originally recorded, and in its place indicating "(Tramadol)". The Plaintiff will aver that the integrity of the entire checklist is therefore questionable and it was possibly created after the fact.***
6. ***The 1st, 2nd and 3rd Defendants were duty bound to disclose how surgery went and provide full information to the Plaintiff to enable him make an informed decision about the care that the deceased was to receive;***
7. ***Failure to give the deceased's next of kin the correct and complete information about the condition of the Deceased after surgery in spite of obvious signs of severe hypoxic brain injury,***

seizures, and failure to regain consciousness (coma) post-cardiac arrest.

8. ***Failure to document whether or not the World Health Organisation Surgical Safety Checklist was done. The Plaintiff will aver that Zambia adopted the 19-item checklist as a renowned tool for decreasing errors and adverse events during surgery, and that the checklist has yielded significant reduction in both morbidity and mortality.***

9. ***Performing an excision biopsy without first resorting to a core needle biopsy. The Plaintiff will aver that a core needle biopsy ascertains the diagnosis of breast mass and would have enabled the 1st and 2nd Defendants to know the diagnosis and then perform appropriate surgical operation in accordance with the guidelines.***

10. ***Failing to abandon the surgical procedure after the cardiac arrest occurred in order to concentrate efforts on saving the life of the Deceased.***

11. ***Failure to timely transfer the deceased to a better equipped facility with intensive care unit wards in a safe manner in order to minimise transfer risk and secondary brain injury. The Plaintiff will aver that at the point surgery was deemed to have been completed, there were obvious signs of severe hypoxic brain injury, seizures, and failure to regain consciousness(coma) post cardiac-arrest.***

12. ***Failure to document whether or not the Anaesthetic Machine Checklist was done as an important part of safe care of the deceased;***

13. ***Administering fentanyl to the deceased who had disclosed that she was allergic to Tramadol.***

14. ***Failing to closely monitor the Deceased on the operating table by following the AAGBI guidelines and not noticing when the deceased developed the suspected anaphylaxis and***

equally not noticing when the Deceased went into cardiac arrest. The plaintiff will aver at trial that the incident was initially noticed by the 2nd Defendant rather than the 3rd Defendant which was detrimental because successful management of perioperative anaphylaxis is critically dependent on early recognition and prompt initiation of specific treatment guidelines or protocols.

15 ***Failure to perform cardiopulmonary resuscitation on the deceased using evidence based decision-making guidelines. The Plaintiff will prove that adrenaline is the main tool used to manage the Deceased's situation and the manner adrenalin was given when the Deceased went into cardiac arrest was too little for the severity of the deceased's reaction. It was 1 mg in 500mls normal saline infusion instead of a bolus of 1mg adrenaline intravenously given at intervals of 2-3 minutes. Furthermore, the 1st and 3rd Defendants administered atropine, calcium gluconate and sodium bicarbonate which have no proven benefit in cardiopulmonary resuscitation in evidence-based medical practice.***

16. ***Failure to manage the deceased's suspected anaphylaxis during anaesthesia using established evidence-based decision making guidelines;***

17. ***In spite of obvious signs of severe hypoxic brain injury, seizures, and failure by the Deceased to regain consciousness post-cardiac arrest, there was a failure to immediately transfer the Deceased to a better-equipped facility with intensive care wards in a safe manner in order to minimise transfer risk and secondary brain injury.***

18 ***Failure to request for a Computerized Tomography (CT) scan of the brain to aid the***

management of the deceased's suspected hypoxic brain injury after a cardiac arrest

19. ***Lying to the Plaintiff by not giving the Deceased's next of kin the correct and complete information about the condition of the deceased after surgery.***

20. ***The 1st Defendant placed the 5th Defendant in a critical care situation without having a specialised critical care nurse to supervise her.***

21. ***The 5th Defendant allowed herself to be placed in critical care situation without being supervised by a specialised critical care nurse.***

22. ***The 5th Defendant had to be told what to do by the Plaintiff and at other times by the Doctors. The Plaintiff will aver at trial that her only role was to be the Deceased's number one advocate for survival, initiating and taking action based on what she was observing.***

23. ***The 5th Defendant exhibited an unprofessional approach of deferring to the doctors in spite of what she was observing. The Plaintiff will aver that the 5th Defendant is part of an interdisciplinary team of professional who each provide care based on their training. She had a duty to the Deceased not to be subservient to the doctors because she spent more time by the deceased's bedside than the doctors and her profession and calling required her to be fearless and to recognise and state that she was not going to be able to provide meaningful care to the deceased.***

24. ***Extubating the Deceased and failing to put her under induced coma to suppress brain activity, thereby limiting options of controlling seizures. Every moment that the deceased was not transferred robbed her of an opportunity for burst suppression in an ICU.***

25. ***Extubating the Deceased before transfer and during transfer to a facility with an ICU.***

Ventilation, controlled oxygenation, and airway protection are vital therapeutic approaches which have been shown to improve outcome in the post cardiac arrest syndrome.

26. ***Waiting for over 4 hours to transfer the deceased in circumstances where the 2nd Defendant had called an ICU 2 hours earlier and been informed of available bed space.***

1.4 The Sixth Defendant, the Heath Professions Council of Zambia (HPCZ), mandated to *inter alia* licence public and private health facilities, monitor quality control and assurances of health facilities and services, was sued for breach of statutory duty. And the particulars of statutory negligence were itemized as follows:

1. ***Incorrectly licencing the 1st Defendant as a private health facility in Class A. The Plaintiff will aver that a correct classification of the 1st Defendant in that category would have meant that there was no need to transfer the deceased to a different private health facility that is also licensed as a Class A, in order to manage her situation.***

2. ***Approval of the 1st Defendant as a health facility that can carry out operations and procedures under general anaesthesia was fundamentally flawed because the 1st Defendant was not equipped to deal with complications that arose in relation to the deceased under general anaesthesia.***

3. ***Failing to continuously monitor the 1st Defendant to ensure that the conditions that prevailed at the date of licensing were maintained throughout the license period.***

1.5 The First to the Fifth Defendants entered appearance and filed a joint defence specifically denying medical negligence alleged by the Plaintiff.

1.6 The Sixth Defendant's also entered appearance and defence on July 26, 2021. It denied breaching its statutory duty of care and averred that it had complied with its mandate under section 4 of the Health Professions Act No. 24 of 2009 (the Act). It was avowed that Viva Med Hospital was granted a Class A Licence because, it met and continued to meet the criteria for the provision of in-patient care for acutely ill persons that require regular monitoring and intervention by a medical practitioner. And that the First Defendant was at the material time capable of carrying out the procedures under general anesthesia.

2.0 BACKGROUND AND ISSUES NOT IN DISPUTE

2.1 The Plaintiff was the husband to the late Agnes Lucia Kaluzi Mdala. The Court was apprised that, the Second Defendant, Dr. Akhtaev is a Consultant Surgeon of 24 years experience in Zambia. The Third Defendant, Dr. Dildora Khajimatova is a Consultant Cardiac Anaesthesiologist of 15 years experience. The Third and Fourth Defendants are registered nurses.

2.2 The Second to the Fifth Defendants as medical staff at Viva Med Hospital respectively and jointly attended to the deceased when she was admitted to Viva Med Hospital on December 18, 2020 as an in-patient, scheduled for lumpectomy procedure.

2.3 Previously, in October, 2020 the deceased discovered a lump in her breast. On October 28, 2020 she visited Viva Med Hospital, and had audience with Dr. Muparrakh, who upon examination

confirmed the presence of a lump in her breast. She was then booked for an ultrasound on October 30, 2020. The ultrasound confirmed the presence of the lump in her breast.

2.4 After discovery of the lump, some antibiotics were prescribed. At the material time the deceased was still breast feeding her thirteen (13) month old baby. On December 2, 2020, when the deceased returned for review, it was noted that the lump was still the same size and had not shrunk and, an appointment for the deceased to consult the Surgeon, the Second Defendant was secured for December 4, 2020.

2.5 On December 4, 2020 the deceased met the Second Defendant for consultation. It is apparent that lumpectomy procedure was proposed, and the operation took place on December 18, 2020.

2.6 And at 15:20 hours on December 18, 2020 the deceased went into theatre for her operation at Viva Med Hospital, but while the excision biopsy operation (lumpectmony), that is to say, removal of the lump was ongoing, the deceased suffered a cardiac arrest. She was then transferred to CFB Medical Center. She never improved and died on December 23, 2020 at CFB.

3.0 THE PLAINTIFF'S CASE

3.1 The Plaintiff relied on his witness statement and was cross-examined, and called Plaintiff Witnesses (PWs). He said his late wife Agnes Lucia Kaluzi Mdala, whom he fondly referred to as "Aggie", was a very health cautious person.

3.2 He recounted that sometime in October 2020 his late wife visited Dr. Muparrakh at Viva Med Hospital, after she

discovered a lump in her breast. He said the lump was confirmed by an ultrasound examination, and thereby Dr. Nigora Musaeva prescribed antibiotics. He said antibiotics were prescribed because at that time, Aggie was still breastfeeding their thirteen month old baby. He said she was advised that if the lump was going to shrink after taking antibiotics, there would be no need for further action except routine check-ups.

3.3 He said the treatment did not work because, when Aggie revisited the Hospital on December 2, 2020 it was confirmed by ultrasound that the lump was still the same. That an appointment was then made for her to see the surgeon on December 4, 2020. He added that on Friday, December 4, 2020 she consulted the Surgeon, the Second Defendant, Dr. Akhta Akhtaev.

3.4 He said following the scheduled consultation, the second Defendant recommended lumpectomy. He explicated that she was advised that lumpectomy was the most ideal procedure. He added that the surgeon explained to her that he would make a small incision along the areola to extract the lump. He added that the surgeon advised that instead of going for core needle biopsy and then an operation later, it was better to have the procedure done once and for all. And that she was told that the procedure would only take 30 minutes. He said Aggie was assured that the procedure was safe.

3.5 He stated that because of the assurance she got from the Second Defendant, despite being very cautious and afraid of operations, she opted for lumpectomy as opposed to a core

needle biopsy. He said with assurances from the Surgeon, the only concern Aggie had was keloid. He said that had the risk such as anaphylactic shock or any risk that would result in severe injury or death had been highlighted properly, his late wife would not have deliberately picked an option with higher risk.

3.6 He said since the surgery was elective, Aggie would not have chosen to have surgery at all, had she been given full information on the risks. According to him, she would have chosen to go for core needle biopsy. He said if the laboratory results showed that the lump was cancerous, she would have consented to lumpectomy.

3.7 He said on December 18, 2020 the day scheduled for the operation, he was in the company of his wife, when he took her to Viva Med Hospital for lumpectomy. He said at about 13:30hours, the Second Defendant had not yet arrived, and when presented with the consent by the Fourth Defendant, Aggie refused to sign until she spoke to the Second Defendant, and until her further questions were answered by the Second Defendant.

3.8 He said that whilst awaiting to go into theatre Aggie's vitals readings were taken and her blood sample was taken to the laboratory for examination. He said the results indicated that she was in perfect health. He said the Third Defendant Dr. Dildora Khajimatova asked her if she had any allergies, and she replied that she was allergic to Tramadol (pain killer) including Tilapia fish, and some game meat. He said the Third Defendant

assured her that everything would be alright, and that Tramadol would not be used. He said the Third Defendant did not write anything.

3.9 He said the nurse at the reception who took Aggie's blood pressure told them that the Second Defendant would walk them through the consent form, but this never happened. He said the operation was characterised as minor one and, major adverse effects or death were never mentioned. He said the operation was supposed to take 30 minutes.

3.10 He said the deceased went into the operation room just after 16:00hrs and never came out of the theatre as scheduled, that instead, the Second Defendant came out of the operating room at 18:20 hours and told him that the lumpectomy was a success, except that Aggie had suffered an anaphylactic shock due to a reaction to Propofol and that her vitals had gone *Pshhhhh*! That she had a skin reaction as well and closure of the throat. And that they had to intubate her in order to stabilize her. He said the Second Defendant assured him that she would be okay.

3.11 He added that, soon after the Second Defendant explained to him what had happened, Dr Musaeva, came out and showed him the lump, as she proceeded to the laboratory. He said he was assured that Aggie was okay, except they were waiting for her to wake up from anaesthesia. He lamented that the First, Second and Third Defendants knew that Aggie had suffered a cardiac arrest, but never told him. And that even after resuscitating her, they knew the complications that Aggie had

suffered and yet they did not bother to inform him. He said when Aggie came out of the theatre, she was intubated and looked lifeless, and Dr. Musaeva told him that she would be fine and that it was just the effect of the anaesthesia.

3.12 He complained that he was not furnished with the right information over what exactly transpired in the operating room to help him timely decide the next point of care. He said despite the allegation that Aggie reacted to Propofol, the First, Second and Third Defendant never reported this incidence to the Zambia Medicine Regulatory Authority (ZAMRA). He added that Aggie was later transferred to Care for Business (CFB) Hospital for ICU services at 20:42 hours. He said he only learnt belatedly that the Second Defendant had earlier called Dr. A. Mwale at CFB to inquire about ICU bed space at CFB.

3.13 He alleged that his wife suffered under the care of the Fifth Defendant. That through his investigations, the Fifth Defendant was not a licensed critical care nurse. He said this was confirmed by the letter dated July 1, 2021, from the Nursing and Midwifery Council of Zambia. That according to their records, Linnah Chibwe was not a registered nurse and registered midwife.

3.14 He said he had to constantly ask the Fifth Defendant why Aggie's constant twitching was becoming worse, while she was doing nothing. He said he had to prompt her to call for doctors. He said when Dr. Musaeva and the Third Defendants came, they never spoke in English, but discussed between themselves

in a foreign language, and was asked to leave the room for a while.

3.15 He said the First, Second and Third Defendants decided to move Aggie to CFB without telling him why they did so, and that this puzzled him, because when he earlier suggested that the same be done, he was told that Aggie could not be moved in her state.

3.16 He said he got his first brief at CFB from Dr. Mwale, an Intensivist and Anaesthesiologist, who told him that Aggie was in a critical state because, she had suffered both a brain oedema and possible hypoxia, cardiac arrest, as well as other things while at Viva Med Hospital. He said this information was not revealed while Aggie was at Viva Med Hospital. He added that Aggie never improved beyond a few positive signs. That she never left the ICU at CFB nor did she regain consciousness and eventually died on December 23, 2020.

3.17 He said apart from the professional breaches committed by the First to the Fifth Defendants none showed compassion. He lamented that even when Aggie was in ICU at CFB, Viva Med Hospital was demanding payment of its dues for a horrible operation.

3.18 He said on June 25, 2021 he wrote to the Sixth Defendant seeking revocation of the licence of Viva Med Hospital as a Class A Hospital to prevent further negligent treatment, but nothing was done, except a promise to institute investigations. He added that he was aware that the Sixth Defendant had conducted a reactive inspection against Viva Med Hospital, but never got in

touch with him to update him on whether Aggie's rights as provided in the Sixth Defendant's Charter were safeguarded.

3.19 In cross examination, when referred to some medical history from CFB, he said he was not aware that his wife received morphine at CFB. And that he did not know if the cause of death was as a result of medication from CFB.

3.20 PW2 was Dr. Mutumba Songiso, a Specialist Surgeon based at Matero General Hospital. In his witness statement he stated that his duties, among many included; conducting two (2) weekly specialist breast cancer clinics at Matero Breast Care Clinic.

3.22 He stated that he had over thirteen (13) years experience, had treated over 3000 women with breast complications since the establishment of the Matero Breast Care Clinic in 2018. He said he was the author of the expert report exhibited by the Plaintiff dated May 6, 2021. And that the same was prepared using: medical reports issued by the First Defendant dated January 11, 2021; an undated letter from the First Defendant explaining the events of December 18, 2020; the deceased's medical records from the First Defendant and a letter dated March 24, 2021 from CFB Anaesthesiologist and Intensivist Consultant, which explained the state in which the deceased was received by CFB and the treatment she received; and the deceased medical records from December 18 to 23, 2020.

3.23 PW3 was Niza Sheyo, a Medical Doctor and Anaesthesiologist. He said he was the Regional Manager of the Zambia National Blood Transfusion Service and practising as a part-time

Consultant Anaesthesiologist. He disclosed that he had to his credit seven (7) years expertise in the administration of anaesthetics to surgical patients during surgical procedures via different methods such as general, local and spinal anaesthesia, and regional blocks.

3.24 He stated that he was the author of the expert report dated May 5, 2021 contained in the Plaintiff's bundle of documents. He said his source of information was: the medical report issued by an undated letter from the First Defendant explaining the events of December 18, 2020; the deceased's medical records from the First Defendant and a letter dated March 24, 2021 from CFB Anaesthesiologist and Intensivist Consultant which explained the state in which the deceased's was received by CFB and the treatment she received, and the deceased medical records from December 18 to 23, 2020.

3.25 It is apparent that the particulars of negligence as stated in the statement of claim are also stated in the expert report: The salient features of the report are here-blow stated:

a. The deceased's anaesthesiologist failed to act in accordance with the standards of an ordinary competent anaesthesiologist as follows:

i. Preoperatively

- ***Failure to document whether or not the Anaesthetic machine checklist was done;***
- ***Failure to document whether or not the World Health Organisation (WHO) Surgical Safety Checklist was done.***
- ***Failure to perform Cardiopulmonary Resuscitation (CPR) using established evidence-based decision making guidelines.***

- ***Failure to manage a patient with suspected anaphylaxis during anaesthesia using established evidence-based decision making guidelines.***

ii. Postoperatively:

- ***Failure to timely transfer a patient to a better-qualified facility in a safe manner in order to minimise transfer risk and secondary brain injury;***
- ***Failure to request for a Computerized Tomography (CT) scan of the brain to aid in the management of the patient with suspected hypoxic brain injury after a cardiac arrest.***

b. The errors that the Deceased's anaesthesiologist made which no doctor of ordinary skill would have made are as follows:

- ***The Deceased anaesthesiologist made an error by not performing a Checklist for Anaesthetic Equipment. A Checklist for Anaesthetic Equipment represents an important part of safe patient care. Hence, when the ,checklist is completed by an anaesthesiologist, a record should be kept on file or the anaesthetic machine that these checks have been done and should be availed as part of the patient's medical record from Viva Med Hospital. The omission of not having done a checklist for Anaesthetic Equipment compromises patient safety which can result in patient harm.***
- ***The Deceased's anaesthesiologist together with the surgical team made an error in not doing the WHO Surgical Safety Checklist...that just like the Checklist for Anaesthetic Equipment, the omission of the WHO Surgical Safety Checklist represents an important part of safe patient care and its omission puts the patient at risk of harm during and after surgery...***
- ***The Deceased's anaesthesiologist made an error in the performance of cardiopulmonary resuscitation (CPR) in the manner adrenaline (1mg in 500 mls normal saline infusion) was given when the patient went into cardiac arrest. The correct dose is a bolus of 1mg adrenaline intravenously given at intervals of 2-3minutes. However, the Deceased's***

anaesthesiologist promptly initiated cardiac compressions when she recognised that the patient was in cardiac arrest and also promptly Defibrillated the patient when she recognised that the patient had ventricular fibrillation. Be that as it may, the quality-of-life support delivered during cardiopulmonary resuscitation affects outcomes which in this case may have been compromised by the low dose of adrenaline.

- ***It is not uncommon to experience preoperative anaphylaxis as an anaesthesiologist and in rare instances the anaphylactic reaction can be fatal. In addition, it is possible that the patient could have developed anaphylaxis during surgery from propofol without prior exposure as reported in the medical report. For the most part, successful management of perioperative anaphylaxis is critically dependent on early recognition and prompt initiation of specific treatment guidelines or protocols. That said, anaphylaxis during anaesthesia frequently presents differently to that which is observed after oral ingestion of allergens or envenomation.... However, the Deceased's anaesthesiologist made an error when dealing with this fatal anaphylactic reaction. Severe anaphylaxis treatment features the use of adrenaline, a drug with a narrow therapeutic index. It is generally agreed that epinephrine (adrenaline) is the mainstay of management and is recommended in all published guidelines. In the medical report from Viva Med Hospital, it is stated that the dose of adrenaline given was an infusion of 500mls normal saline. The dose of adrenaline in 500ml normal saline infusion given was too little for the management of a severe anaphylactic reaction. Over and above, the dosing of adrenaline should match the severity of the reaction and the treatment goals.***

Post-operation

- ***The Deceased's anaesthesiologist made an error in her communication with the next of kin (husband to the deceased) with regards to the right of complete information regarding the health to the right of complete information regarding the health condition of the deceased. According to the Health Professions'***

Council of Zambia: Patients Rights and Responsibilities Charter, it is the duty of the attending health practitioner to give the patient or the next of kin the correct and complete information about the condition of the patient. The patient had obvious signs of sever hypoxic brain injury: seizures, and failure to regain consciousness (coma) post-cardiac arrest. Clinical seizures can be a sequel or complication of cardiac arrest and indicate poor outcomes with limited specificity....

- ***The Deceased's anaesthesiologist made an error by delaying to transfer the patient to another facility with ICU wards.... According to the response letter from CFB the Managing Surgeon at Viva Med Hospital called CFB Hospital Intensivist around 18:00hours (2 hours post-the cardiac arrest) to inquire about availability of ICU bed space at CFB Hospital without providing details of the patient's condition, confirmation of transfer of patient and expected time of arrival. Possibly because of the planning and preparation of the patient for transfer, the patient (not intubated) only arrived at CFB Hospital at 20:55 hours. There was a delay of approximately 4 hours in taking the patient to another facility with ICU space despite the husband offering to arrange for such services earlier on.***
- ***The deceased's anaesthesiologist erred by not requesting for a Computed Tomography (CT) scan to either confirm the diagnosis or aid in the management of the patient for a probable good outcome. In addition, the Deceased's anaesthesiologist erred by not confirming the causative agent of suspected anaphylaxis and not reporting the critical incident for pharmacovigilance. This omission has robbed the due processes of critical information for confirming or disapproving that the cause of the suspected anaphylaxis of "propofol"***

3.26 He further acknowledged that;

- ***It is possible to get an anaphylactic reaction from propofol, but the risk is very small with an incidence***

of anaphylaxis during anaesthesia estimated between 1 in 10,000 and 1 in 20, 000. However, in this case of the Late Mrs. Agnes Lucia Kaluzi Mdala, there is also an extremely rare risk of anaphylaxis from fentanyl since she had a previous history of allergy to tramadol. Additionally, Mrs. Agness Lucia Kaluzi Mdala could have reacted to ketamine which was administered at the same time as propofol and fentanyl. Furthermore, it is a possibility that the patient could have reacted to latex gloves. Therefore, the actual cause of the anaphylaxis cannot be determined using the provided reports. However, the Managing Anaesthetist who gave the anaesthetic is responsible for ensuring that the reaction is investigated to establish the causative agent and report the incident to Zambia Medicines Regulatory Authority (ZAMRA) for further investigations and pharmacovigilance.

3.27 And as for the management of seizures, the report states that:

- ***Seizures are not typically reported to be a direct manifestation of anaphylaxis. In fact, literature says that when seizures occur as a direct result of anaphylaxis there are usually brief. However, clinical seizures are common after a cardiac arrest following hypoxic brain injury and may be intractable (status epilepticus), myoclonic, tonic-iconic or a combination of seizures in the deceased were as a result of brain anoxia or hypoxia due to the cardiac arrest unlike as a direct effect of the anaphylaxis. That said, the primary brain injury which led to the seizures could not have been avoided because the insult had already occurred as a result of a cardiac arrest, but the intractable seizures could have been mitigated by keeping the patient intubated and put under induced coma to suppress brain activity known as burst suppression in ICU. But in this case, the Managing anaesthesiologist decided to extubate the patient which limited her options of what she could use for controlling the seizures.***

3.28 And as to the cause of cardiac arrest and what ought to have been done by the Managing Anaesthetist: it was reported as follows:

- ***Close monitoring of the patient on the table by following the AAGBI guidelines: a trained anaesthesiologist must be present throughout general anaesthesia, and the anaesthesiologist must care for the patient continuously. These guidelines help to timely recognise changes in the patient's condition and to recognise potential signs timely which can lead to a cardiac arrest. However, from the review of the medical records provided by Viva Med Hospital, the incident was initially noticed by the Surgeon and not the Managing Anaesthesiologist. This evidence is supported by bullet in the report saying, Noticed that incision site and tissue not bleeding and bluish in colour". This possibly means that the Anaesthesiologist did not notice when the patient developed the suspected anaphylaxis and equally did not notice when the patient went into cardiac arrest. So, then this may indicate inadequate monitoring of the patient by the Anaesthesiologist. Nonetheless, according to the notes in the Viva Med Hospital, the Managing Anaesthesiologist did most of guidelines of managing a cardiac arrest after she recognised the incident. That is not to say there were no omissions in the resuscitation like dosage of adrenaline, the sequence of the manoeuvres, and the other drugs given (atropine, calcium gluconate and sodium bicarbonate). Atropine, calcium gluconate and sodium bicarbonate have, no proven benefit in CPR in evidence-based medical practice.***

3.29 And as to the impact in delay to transfer the patient to the care of an intensivist and its alleged contribution to the deceased's death, it was stated:

- ***When a patient has a cardiac arrest, and they are resuscitated with a return of spontaneous circulation***

(ROSC), they develop prolonged whole-body ischemia (lack of oxygen) depending on the length of the cardiac arrest that is known as the post-cardiac arrest syndrome. Post cardiac arrest syndrome can be divided into four phases. The immediate post-arrest phase occurs in the first 20 minutes following a return of spontaneous circulation (ROSC). The early post-arrest phase occurs between 20 minutes and 6 to 12 hours after ROSC. Early interventions may be effective in this window of time. The intermediate phase is between 6 to 12 hours and 72 hours when injury pathways are still active, and aggressive treatment can be imitated. Hence, in terms of timing, the Managing Anaesthesiologist was still within the time where early interventions by the intensivist would have been effective. Nonetheless, every second counts. Meaning, the earlier the intervention, the better, the likelihood of a good outcome.

- ***However, extubating the patient before transfer and during transfer to a facility with an ICU could have contributed to the Deceased's death. Ventilation, controlled oxygenation, and airway protection are potential therapeutic approaches which have been shown to improve outcome in the post-cardiac arrest syndrome. The three above-mentioned therapies can only be adequately achieved when a patient is intubated particularly when the patient is unconscious and with intractable seizures as the case here.***

3.30 In cross examination, he stated that the failure to document the checklist means that it was not done. According to him, anaphylaxis is reaction of the body to something which may in some cases result in death, if not attended to promptly. And that it was possible for symptoms to be masked, when the patient is under anaesthesia. And that the symptoms would be more visible once the anaesthesia has worn off.

3.31 According to him, two things were being mixed up, that is; masking anaphylaxis and an issue of monitoring the patient. That for the wound to become bluish meant that the heart had stopped functioning, and that this could take about three minutes. And that this should have been spotted earlier by the Anaesthesiologist before the Surgeon. He said he had issues with the Anaesthesiologist, the Third Defendant. He said the record of the Anaesthesiologist was poor as there was no time attached, and this was below professional expectation. And according to him, based on the Anaesthesiologist notes, the BP and heartrate were not monitored. He said there was lack of team work between the Surgeon and the Anaesthesiologist. And that in the documents presented, there was no indication of a flat line. He said this is because the patient presented bluish colour at the cut and there was no bleeding, and she had flat lined. He said the patient was resuscitated successfully.

3.32 And as for the medication, he said the bolus Adrenaline should have been undertaken straight into the patient's vein as opposed to infusion through a liquid. He explained that when a patient is experiencing fibrillation (that is shaking of the heart and not contracting normally), Adrenaline can be administered. He conceded that the patient was defibrillated. According to him, harm was done because the correct procedure to administer the correct amount of Adrenaline and defibrillation, were not done.

3.33 He said the sequence of manoeuvres of cardio-pulmonary resuscitation administered on the Plaintiff had irregularities. He

said one can only tell if one is in theatre and in this case, he was not in theatre.

3.34 And as to the allegation that the Plaintiff extubated, he said it was not possible that she extubated during transfer from the theatre to the ambulance, because the patient was unconscious. He said it was possible the extubation occurred during the process of transfer. He said there was no risk when it comes to intubation during transfer. And that this skill should have been exercised. He said the Plaintiff was having intractable seizures and that accidental extubation can happen in a patient fitting.

3.35 He said the patient was transferred to CFB and that the referral for CT scan was not documented and that when she was transferred to CFB, she should have undertaken the CT scan.

3.36 And regards the failure of a pharmaco-vigilance procedure, he stated that whenever an anaphylaxis occurs, it was supposed to be reported to Zambia Medicines Regulatory Authority (ZAMRA).

3.37 And in respect of the attendant nurse, he said the Fifth Defendant was not a critical care nurse. And that a nurse working under the supervision of a critical care specialist need not be a trained in critical care. He added that doctors have a right to treat a patient after cardiac arrest and that this should be done by the best practise available. According to him, two hours 15 minutes was too long a period of time post the cardiac arrest. He added that the MRA and the post-mortem

examination were not done, as such the ultimate cause of death was not ascertained.

3.38 According to PW3, the patient did not suffer from a stroke. And that the patient's father, who was indicated as the next of kin was stated to have directed that doctors should stop morphine use on the patient.

3.39 He added that the issues in dispute had nothing to do with the Health Professions Council of Zambia, as the regulator.

3.40 PW4 was Christabel Beatrice Kaluzi, the deceased's elder sister. Her testimony was similar to that of PW1. She said that after her sister discovered a lump in her breast, she decided to face the challenge despite being scared, for the sake of her daughter, Ariela. She said following the failure of treatment by Dr. Musaeva to try and reduce the lump, her sister told her that it was recommended that lumpectomy would be an ideal procedure, and that the surgeon would make a small incision along the areola to extract the lump.

3.41 That according to her sister, lumpectomy was recommended rather than to go for biopsy only and having the possibility of still having to operate. That it was better to get it over and done within one procedure. And that her sister was told that the procedure would be done under general anaesthesia, and would take approximately 30 minutes and the procedure was not complicated.

3.42 She stated that when her sister booked for the procedure, she was anxious about it because, she was aware about the allergies she had. She said the deceased assured her that the First

Defendant had assured her that the Second Defendant had performed the surgery many times on other patients and all the procedures were successful. She said when she asked her sister why the procedure could not be done under local anaesthesia, her sister told her that the Second Defendant told her that considering the location of the lump in the breast, local anaesthesia would not be recommended.

3.43 She added that knowing how her sister was, if she had been told that there was risk of death, or had she been advised fully, Aggie would not have gone ahead with the procedure, because remaining alive for her daughter was the more reason she wanted to find out if the lump was problematic. And that her sister always took the option that carried less risk or took steps whose consequences she knew for certain.

3.44 She said she believed that the Second Defendant explained to Aggie the comparative simplicity of a core needle biopsy and the comparatively low level of risk hereof as against lumpectomy. That these were factors that her sister would have considered and she would have gone for a core needle biopsy to extract sample to be tested, and that after the laboratory results her sister would have decided what step to take next. She said if the test results indicated that the lump was harmless, she would not have under-gone an operation to remove it for cosmetic reasons.

3.45 She said on December 18, 2020 the day of the lumpectomy procedure, Aggie dropped off the child at her house and at about 17: 20 hours her brother-in-law (the Plaintiff) informed her that

the lump had been removed, but that Aggie had gone into anaphylactic shock after administration of anaesthesia, and that her vitals dropped.

3.46 She said when she went to the Hospital to check, the Plaintiff assured her that Aggie was okay and that she was being taken to the ward to wait for her to wake up, but was later informed that she was convulsing. She said she knew if they kept her there long, she would die because, there was no sense of urgency on the part of the Defendants. And that the Defendants insisted on waiting for her to wake up even when they could clearly see that there was a problem with Aggie's condition.

3.47 She said it was only on Saturday morning that she and Jimmy got their first briefing from CFB, where they learnt that Aggie had suffered a cardiac arrest while at Viva Med Hospital. According to her, she believed the Defendants did everything wrong on the fateful day.

3.48 In cross examination, she stated that the notes in the medical report stated that her sister preferred lumpectomy. She said her sister went an extra mile to research on the procedure and she was happy with what she found. That had she not been happy, she would not have opted for lumpectomy. She said her sister had allergies, which included pork and kapenta. And on the medicine side she reacted to painkillers, Tramadol.

3.49 She said her father gave the instruction not to administer morphine, because it was a strong drug. She said they wanted to find out what killed her, which according to her, was the cardiac arrest. And that she had not provided proof that it was

cardiac arrest that killed her sister. She said the treatment from CFB could not have killed her sister, even though there was no document that excluded that possibility.

3.50 According to her, the treatment should have stopped the convulsions, but the doctors did nothing. And that a day after the operation, the convulsions did not stop. She said she had expected that CFB would stop the convulsions. She said the cause of death as indicated by CFB was cardiac arrest. She conceded that no post-mortem examination was conducted to ascertain the cause of death.

3.51 The Plaintiff did away with the rest of his other witnesses, he listed to call, namely Kwesi Formson and Deepak Kodeira Hrish Karanth.

4.0 THE CASE FOR THE DEFENCE

4.1 The First to Fifth Defendants testified and called two other Defence Witnesses (DWs).

4.2 DW1 was Penius Tembo, a Medical Surgeon at the University of Zambia, Adult Hospital, whose witness statement was filed on May 4, 2022. He listed his medical credentials. He said he was the author of a medical report titled: *Lumpectomy* exhibited in the supplementary bundles of documents for the First to Fifth Defendants.

4.3 In his report he started by giving a general synopsis of lumpectomy, types of lumps that can present in females, types of assessments that can be conducted to confirm the presence if there is a lump in the breast and, medical procedures for

medical relief. He thus listed the following procedures: Fine Needle Aspiration for Cytology (FNAC), the Trucut Biopsy where a strip of tissue is collected from the lump using a special equipment, which tissue is then examined by a histopathologist. He said this type of examination is easier to examine unlike cytology in FNAC.

4.4 He also listed incisional biopsy which involves cutting off a small piece of the lump, where the lump is big. And the last method is the excisional biopsy also called lumpectomy which is a procedure done to remove the whole lump. He stated that this procedure may be therapeutic and that in benign condition, once the lump is removed it is treatment, and the specimen is taken to the laboratory for the final reporting of the exact nature of the lump.

4.5 He said in excisional biopsy or lumpectomy some form of anaesthesia is used. And that this is often discussed with the patient in the preoperative stage. And that basic investigations like the estimate of haemoglobin levels are also done to establish fitness of the patient to undergo anaesthesia. He said three types of anaesthesia are local, regional and general.

He explained that with local anaesthesia, only the site of the lump is infiltrated with the drug to make it numb. And for regional anaesthesia, intercostal nerves are blocked away from the lump so that the patient does not feel any pain at the target site. And as for general anaesthesia, he said the patient is put to sleep. And an anaesthetist monitors the vitals of the patient

during the operation, the pulse, heartbeat, respiration and blood pressure of the patient.

4.6 The witness further outlined the steps taken in the lumpectomy process. According to him, the surgical safety checklist is routinely observed according to the World Health Organisation (WHO) rules by the operating team. And that this observation is not usually written or documented in the operative notes, but merely discussed verbally. And that the teams identified are the surgical team, the anaesthetic team and the nursing team. That the type of anaesthesia is discussed prior to the operation and on the day of the operation, it is discussed and the patient agrees. He said that it was the patient that chooses the type of anaesthesia.

4.7 He said lumpectomy is a minor surgery and bleeding is usually minimal, and after the operation, the patient is discharged the same day, and is reviewed after a week. And that depending on the report from the laboratory, further action may be taken or not, but if the lesion was benign, the patient is completely discharged.

4.8 According to DW1, in an event of complications such as cardiac arrest, resuscitation is required. That the team conducting the surgery stops the operative procedure to assist in the cardiopulmonary resuscitation. And that the operation may continue when the patient is stable. And that the decision whether to continue with the operation or not depends on all the three teams having considered the vital signs like the pulse,

the blood pressure and the oxygen saturation. According to him, there are no hard and fast rules, but "real time judgment".

4.9 In cross examination, he stated that he was more of a surgeon than a lecturer. He admitted that his report appeared like an assignment on lumpectomy. And that his report referred to the procedure. He said he had a look at some of the medical reports. He said he was not there at the time of the surgery and he could only rely on the information that was supplied that the WHO Checklist was done, even though he could not say with certainty. He said considering the calibre of people who were operating, he was certain that the checklist was done. He said he was not sure when the WHO Checklist was introduced. He said even if he personally observed the WHO checklist in his practice, he does not record it.

4.10 He said he did not recall seeing a signed consent form by the patient, and the consent form that appeared on pages 18 of the First to Fifth Defendants' bundle of documents contained only the patient's names but not her signature.

4.11 According to him, the patient should have signed. He said, it was not an ideal way to conduct lumpectomy without the patient's signature.

4.12 DW2 was Dr. Feruza Ismailova, a Consultant Anaesthesiologist at the Apex Medical University. She gave a litany of her medical qualifications. She said her report was based on her review and assessment of the medical records availed to her from Viva Med Hospital and CFB.

4.13 In her report she stated that the WFSA WHO standard requires that every patient scheduled for surgery is preoperatively evaluated and optimised by a competent anaesthesia provider to minimise risks of both anaesthesia and surgery (ASA-risk classification).

4.14 She added that her review of the documents indicated that the preoperative evaluation was conducted and documented by the attending anaesthesiologist.

4.15 And as to the WHO Surgical Checklist, she stated that, the checklist should be done to implement the standard protocols by the whole team to ensure safety of the patient and care applied. And that the checklist was essential to do in each case, but it was not mandatory to document the same in the file.

4.16 She further stated that according to her review of the documents, the patient developed severe cardiovascular collapse and presumed diagnosis was anaphylactic reaction to one of the anaesthetic drugs administered.

4.17 She explained that an anaphylactic reaction (anaphylaxis) is severe, life threatening, generalised or systemic hypersensitivity reaction. She said that anaphylactic reaction during anaesthesia is rare, but potentially associated with severe morbidity and mortality. She added that according to statistics–incidence of anaphylactic reaction is between 1 in 4000 to 1 in 20,000.00 and outcomes depends on many factors. She said that during anaesthesia, usual signs and symptoms such as circulatory, cutaneous and respiratory changes,

profound hypotension, urticaria of anaphylactic reaction are masked. And that diagnostic challenge might delay treatment.

4.18 She said management of anaphylaxis if diagnosed is managed according to the AAGBI guidelines as follows:

a. Use ABC approach (Airway, Breathing, Circulation,). Team working enables several tasks to be accomplished simultaneously.
b. Remove all potential causative agents (including IV colloids, latex and chlorhexidine) and maintain anaesthesia, if necessary, with an inhalational agent.
c. Call for help and note the time.
d. Maintain the airway and administer oxygen 100%. Intubate the trachea if necessary and ventilate the lungs with oxygen.
e. Elevate the patient's legs if there is hypotension.
f. If appropriate, start cardiopulmonary resuscitation immediately according to Advanced Life Support Guidelines.
g. Administer adrenaline intravenously. An initial dose of 50lg (0.5 ml of 1: 10,000 solution) is appropriate (adult dose). Several doses may be required if there is severe hypotension or bronchospasm.
h. If several doses of adrenaline are required, consider starting an intravenous infusion of adrenalin (adrenalin has a short half-life)
i. Administer saline 0.9 % or lactated Ringer's solution at a high rate via intravenous cannula of an appropriate gauge (large volumes may be required).

4.19 She said her findings based on what was done to resuscitate the patient, Adrenaline was given as an infusion to manage severe hypotension and within seconds the patient developed ventricular fibrillations, which was followed by cardiopulmonary resuscitation (CPR) and defibrillation (electrical shock) and this resulted in the return of spontaneous circulation (ROSC). She said that due to successful

defibrillation bolus was not given. According to her, bolus would have only been necessary if the electrical shock was not successful as per AAGBI guidelines. According to her, the estimated time of cardiopulmonary resuscitation in the present case was about 5 minutes which was a good/positive outcome.

4.20 DW2 further stated that post cardiac arrest management requires critical care facilities which the first Defendant did not have available, as such, the decision to transfer the patient to the next facility was appropriate. That the standard requirements (AAGBI) for a patient with return of spontaneously circulation (ROSC) who does not regain consciousness are further entered into post cardiac arrest management strategy in critical care unit for a period of 72 hours. According to her, there were five phases of post cardiac arrest syndrome:

1. ***Immediate care- initial 20 minutes following the spontaneously circulation (ROSC);***
2. ***Early Phase: from 20 minutes to 6-10 hours, when critical protective and therapeutic measures are required for good outcome;***
3. ***Intermediate phase- 6-10 hours to 72 hours a close monitoring and ICU treatment should be applied;***
4. ***Recovery phase-period after initial 72 hours when clearer diagnosis and more predictable results could be made; and***
5. ***Rehabilitation phase-focuses on the patient's complete recovery.***

4.21 She stated that based on the presented file, the patient was transferred to another facility with ICU facility within early phase of post cardiac arrest syndrome, which action was appropriate.

4.22 She said up to the time the patient was handed over to CFB, the Anaesthesiologist had been present throughout, which according to her was satisfactory standard of care given to the deceased.

4.23 She also made the following observations and findings:

4.23.1 ***The post cardiac arrest management in critical care until the time the patient died was not presented and review of the critical management of the patient was not done which had the potential to help provide a clear picture of the outcome. The contributions of various aspects of care to death of the patient, such as thrombosis, previous exposure to Covid infection which could be a cause of coagulopathy or stroke. And that the deceased did not undergo a post-mortem examination which was necessary to establish the actual cause of death. And there was need to assess the treatment the patient received from CFB.***

4.24 In cross examination, she stated that Dr. Dildora Khajimatova (the Third Defendant), was a colleague of hers. That she was her friend on *Facebook* and they a had performed surgery together, in 2018, when they separated the siamese twins at the UTH.

4.25 She said she could not confirm if there was an anaesthetic machine at the First Defendant, because she did not see it in the record. She said, she did not agree that it was the Second Defendant, the Surgeon who discovered that something was wrong with the deceased in the theatre. She said she did not agree that the heart had stopped for three minutes. She also stated that when the flesh is bluish, it did not necessarily mean that the heart had stopped. She said the deceased was connected to a monitor and the monitor would indicate that the

bleeding had stopped. She said the monitor beeps when there is low BP or the heart rate increases or decreases. And that the reading of the monitor is followed by the anaesthesiologist.

4.26 She said that if the patient had hypotension, the legs should have been raised or elevated, but that there was nothing that indicated that her legs were elevated. She said the Third Defendant believed she was treating hypotension, and that she did not deviate from the standard of treating anaphylactic. She said in an emergency situation the most important are bullet points: a, b, and c as per the AAGBI Guidelines. She said some of the guidelines she would ignore. She said the reading of BP/ 70/20 meant that this had gone beyond severe hypotension and it was not cardiac arrest. She said with that reading, she would be treating hypotension and not cardiac arrest.

4.27 She said she was aware that the patient was not extubated when she arrived at CFB and that the Third Defendant was present in the ambulance and was working. She said she did not read medical reports from CFB, and did not provide an assessment of the same. She said from her experience, she never documents the WHO Checklist and that she personally had no such report. She said the checklist is on the board in theatres and cannot be ignored.

4.28 In re-examination, she stated that if defibrillation or electric shock is done twice and no spontaneous heart activity returns, then bolus of adrenaline is administered.

4.29 DW3 was Nasrin Patel, the fourth Defendant. She said she was a registered nurse at Viva Med Hospital. She said on Friday

December 18, 2020, she was on duty performing her day shift from 07:00hours to 18:00 hours. That at 14:00 hours a patient, Mrs. Agness Lucia Mdala walked into the Hospital treatment room and presented to her a booking form for her scheduled operation. She said she sent the patient to the doctor on duty, Dr. Akbarova who examined the patient and sent her back to the treatment room for preoperative preparation.

4.30 She said she checked the patient's vital signs thus; blood pressure, pulse rate and temperature and that she also inquired from the patient if she had any allergies. She said the patient initially denied having any drug allergies and she immediately recorded it in the OT Checklist. She said the patient inquired if the surgeon was already in and stated that she had further questions to ask the Surgeon before she could sign the consent form.

4.31 She said when the Surgeon (the Second Defendant) arrived, she walked with him to the patient's room where the patient made further inquiries and the Second Defendant addressed them. And that when the Surgeon asked the patient about any known allergies, the patient said that she was allergic to Tramadol. She said this new information prompted her to change the earlier recorded information on the known allergy section on the preoperative form. She said instead of making a clear cross on the information, she rubbed the previous entry by completely shading the statement. She stated this was not the correct procedure for correcting the form and that the same was done due to human error on her part.

4.32 She said she handed over the patient to a theatre nurse and that at the time she knocked off at 18:00hours the patient was still in theatre undergoing the procedure.

4.33 In cross examination, she stated that between 1st to 10th July, 2021, she was interviewed by personnel from the sixth Defendant with regard to the deceased. She said she was a registered nurse and that she did not act as a critical care nurse to the deceased.

4.34 She said before the surgery, she was the deceased's contact nurse. She said she was authorised to give her information and to get information from her. She said the information was recorded depending on how the patient was giving it. She said she could not recall the people who were present, but the Plaintiff was present when she gathered the information from the patient.

4.35 She said the full name recorded on the consent form by the patient is also considered as her signature. She said that when someone is giving their full name it means that they have agreed. She said the deceased wrote her name when they went to see the second Defendant.

4.36 DW4 was Linnah Chibwe, the Fifth Defendant. She said she was a registered nurse/midwife at Viva Med Hospital. She stated that the late Agnes Mdala was first attended to by the gynaecologist at the Hospital for antenatal clinic and successfully gave birth in 2019.

4.37 She said on December 18, 2020 she was on duty at the Viva Med Hospital from 18:00 hours to 07:30 of December 19, 2020.

She said at about hand-over time at 18:10, Sister Nasrin Patel and colleagues informed her, and her other colleagues that the deceased was undergoing lumpectomy and was still in the operating room.

4.38 She said at 18:20 hours, the patient was brought to the recovery room from the operating theatre still under the influence of anaesthesia and she was put on a bed at about 18:35 hours.

4.39 She said she was assigned to the deceased and was instructed by the attending Anaesthesiologist, Dr. Dildora Khajimatova to closely monitor the patient. She said the patient was intubated and sedated, but was breathing spontaneously, and that Dr. Dildora told her that she would be in the consultation room in case of anything. She said at 18:50 hours after the patient had been connected to the heart monitor, the patient's husband (the Plaintiff) walked into the room saying: "If anything happens to you, I will not forgive myself, and do this for Ariela".

4.40 She said despite the interaction, as a nurse with the Plaintiff, she never assumed the duty or responsibility to provide full information about the patient's condition. She added that that was the province of the doctors, who to the best to her knowledge did their duty.

4.41 She said at 19:00hours, she noticed that the patient began to jerk, and that when the Plaintiff inquired whether there was something that she could do, she told him that it was normal for patients recovering from anaesthesia to make abnormal movements. She said immediately after that, she informed the two Doctors, Dr. Musaeva and Dr. Dildora, who came to review

the patient, and was directed to administer Diazepam 10mg intramuscularly which she administered at about 19:20 hours.

4.42 She said she closely monitored the patient and recorded her findings every 10 minutes in the patient's observation chart. She said, she never neglected or left the patient alone apart from the two occasions she went to call the doctors. That at 19:40 hours she noticed that the jerking movements increased despite the dosage of Diazepam, and informed Dr. Dildora, who immediately reviewed the patient.

4.43 She stated that Dr. Dildora instructed her to administer Phenytoin 100mg IV which was given and was instructed to count the number of jerks per minute. She said at 20:11 hours, the number of jerks per minute were 14 and again, she was asked to administer Potassium Chloride 150mg in 500mls DNs which was commenced. She explained that she was also immediately instructed to prepare the patient for referral to CFB Medical Centre for intensive care, which she did. She added that once the ambulance arrived, and whilst still connected to the monitor, the patient was transferred to the stretcher with the help of the ambulance staff, the doctors and her other colleagues. She said at around 20:40 hours, the patient was accompanied to CFB by Dr. Musaeva and Dr. Dildora.

4.44 She denied being prompted by the Plaintiff to carry out her duties.

4.45 In cross examination, she said she did not act as a critical care nurse to the deceased. She said her name at Viva Med Hospital

was under neonatal. She said the deceased was not a neonatal patient.

4.46 In re-examination she stated that the last "20:05 hours" recorded in the observation chart was a clerical error, it was supposed to be 20:45 hours since that was the last reading when the patient was placed in the ambulance.

4.47 DW5 was Dr. Nigora Musaeva. She stated that she was an Obstetrician and Gynaecologist and the Medical Director at the Viva Med Hospital, she said the late Agnes Mdala was first attended to by the gynaecologist and successfully gave birth in 2019.

4.48 She said on October 28, 2020, the patient was presented to Dr, Muparrakh, a Gynaecologist with a history of breast lump. A breast ultrasound was done which revealed an irregular hypo echogenic mass. And that after antibacterial and anti-inflammatory treatment, a further ultrasound scan did not show any improvement and the patient was referred to a surgeon who booked her for a lumpectomy on December 18, 2020.

4.49 She said on December 18, 2020 she was conducting clinics in the afternoon, between 15:00 hours and 16:00hours, when she was urgently called to the theatre, where she found the patient intubated. She said Dr, Dildora, Dr. Akhtaev and Mr. Mulenga were resuscitating the patient after a cardiac arrest. She said she assisted with the resuscitation and it was successful. She said when the patient stabilized, Dr. Akhtaev finished the

dissection of the lump, and Dr. Dildora decided to keep the patient in theatre for some time.

4.50 She said at 18:00 hours, she was informed that the patient was ready to be transferred to the High Dependency Unit (HDU), and since the HDU was already occupied by another patient, she instructed the staff to move all the necessary equipment to the recovery room, where the patient was initially taken to, from the theatre. She said she had the patient transferred to the ward, while still intubated, the breathing was spontaneous, but her vitals were within the acceptable range.

4.51 She said considering the condition the patient was in, Dr. Dildora and herself remained at the Hospital. And that at 19:00 hours Linah Chibwe, the nurse they had left to attend to the patient informed them that the patient was twitching in the right side of the arm and face and, Dr. Dildora prescribed Diazepam, and the same was administered immediately.

4.52 She said she had a short conversation with the Plaintiff, whom she had asked to enter the ward and sit next to the patient. She said she explained to him that the patient might need to be transferred to an intensive care unit. She added that at that time, they were trying to stabilize the deceased. She said she assured the Plaintiff that they were doing all they could to stabilized the patient.

4.53 She said when the convulsions did not stop despite administration of Diazepan, Dr. Dildora prescribed Phenytoin which also did not help. And that at 20:00 hours, Dr. Akteav reviewed the patient and a decision was made to transfer the

patient to a facility with an intensive care unit. And that the purpose of the transfer was not only to have access to an intensive care unit facility with a full time anaesthesiologist and intensivist, but also to conduct a CT scan in order to find out the cause of the convulsions. She explained that the convulsions could have been as a result of so many other factors such as; post cardiac arrest, hypoxic encephalopathy, haemorrhagic or ischemic stroke, or electrolyte imbalance.

4.54 She said the Plaintiff was informed about the transfer and he was asked to which facility the patient should be taken to, and that he settled for CFB. She said Dr. Akhtaev arranged for the transfer and at about 20:20 hours the patient was transferred to CFB.

4.55 She said in the process of transferring the patient, the patient self-extubated and Dr. Dildora decided to re-intubate the patient at CFB rather than in the ambulance since SpO2 was normal.

4.56 She added that at no time did the Plaintiff request for a transfer, and that he was too anxious to make the decision about where to transfer the patient and instead called his boss. She admitted the fact that while some of the doctors in the medical team discussed among themselves in Russian, the deceased's husband was not addressed in a foreign language.

4.57 She said after the transfer to CFB, she remained compassionate to the patient and concerned for her well-being. She said she used to check on the patient's condition by calling the Plaintiff.

She added that due to professional ethics and medical practice they were prohibited to release medical records of patients to unidentified individuals, whose relation to the patient or authority to receive such records was unverified. She said upon production of the letters of administration/probate by the Plaintiff's Advocates, the records were immediately released.

4.58 She added that following the occurrence, a sample of Propofol administered to the patient was sent to the Food and Drugs Laboratory at the Ministry of Health by Viva Med Hospital through Mr. Peter Monze of Chilenje Level One Hospital on December 18, 2020 for toxological analysis. She said on September 10, 2021, the analysis report detected no toxins in the propofol sample.

4.59 According to her, Viva Med Hospital is a Class A Hospital, in accordance with the law and that the licence was successfully reviewed and inspected by the Health Professions Council of Zambia as per the July 16, 2021 Report.

4.60 DW6 was Dr. Akhta Akhtaev. He said he was a Consultant Surgeon at Teba Care Hospital and other private hospitals with 44 years experience, and an overall 25 years working experience in Zambia.

4.61 He said the late Agnes Mdala was referred to him on December 4, 2020 after antibacterial and anti-inflammatory treatment failed to reduce the breast lump she had.

4.62 He said following examination of the patient, he explained to the patient the options available, namely core needle biopsy and lumpectomy. He said as part of the discussion before surgery,

he drew a scheme to the patient to show how the incision will be made. She said the patient's only concern was that her skin usually heals with keloid scar. And that the patient chose lumpectomy since she wanted only a one step procedure. According to him, lumpectomy was therapeutic in cases of benign tumors. And that it is at the surgeon's discretion, unless the surgeon is uncertain about the lump and the volume of the procedure.

4.63 She said preliminary booking for surgery was scheduled for December 18, 2020 and that the patient was asked to discuss the procedure with her family and to confirm the booking once she was ready for the procedure, and the patient later did.

4.64 He added that before surgery was undertaken, the following measures were done:

i. having the consent form signed;
ii. discussing with the patient and the Plaintiff the type of procedures, possible complications, type of incision, length and procedure; and
iii. performing with the patient step by step the Surgical Safety Checklist which is a routine preoperative step conducted on all surgical patients.

4.65 He said during the operation, the patient developed complications which at the time were suspected to be cardiovascular collapse, whose cause seemed to be a reaction to the anaesthetic drug. He said when the complication started, the surgery was very advanced and had almost completely dissected the lump. He said the surgery was immediately abandoned and resuscitation was performed by the team. He said when the patient was sufficiently stabilized, he completed

the surgery and closed of the incision wound which took a very short time.

4.66 He said after the surgery, the patient was managed and monitored by the Consultant Anaesthesiologist and was never left without medical supervision.

4.67 He said when he reviewed the patient, it was agreed with the medical team that she needed to be transferred to a facility with an intensive care unit. He added that at approximately 20:20 hours, he personally called Dr. Abel Mwale of CFB to arrange for space for the patient. He said the patient was successfully transferred to CFB.

4.68 He said when informing the Plaintiff, he did not give detailed explanation using medical terminology such as cardiac arrest, but explained to the Plaintiff what had transpired during surgery and that they had to resuscitate her. He added that he also spoke Russian with some of the medical team members on the basis that the same was their fluent language. He said he did not speak using Russian to the Plaintiff.

4.69 According to him, by writing her name on the consent form, the patient consented to the procedure. He added that lumpectomy does not cause cardiac arrest or death. And that the anaphylaxis shock was for the Anaesthesiologist to explain.

4.70 DW7 was the Third Defendant, Dr. Dildora Khajimatova, a Consultant Cardiac Anaesthesiologist working at the University Teaching Hospital and other private hospitals with 15 years of experience. She said Agnes Mdala was admitted for surgery at Viva Med Hospital on December 18, 2020. She said she was

required to administer anaesthesia to the patient as part of the medical team that included the Consultant Surgeon, Dr. Akhta Akhtaev (DW6).

4.71 She said as mandated by the WHO Surgical Safety Check List and the Anaesthetic Machine Checklist were done in the presence of the surgical team members. She said she started administering anaesthesia drugs, with Propofol 100mg, Fentanyl 25mcg and Ketamine 50mg. And that the anaesthesia was maintained on halothane 2%,02 41/min and Ketamine 50mg and that she informed the Surgeon that he could start the procedure.

4.72 She said that within approximately 10 minutes, the patient developed profound hypotension followed by cardiac arrest. She said she tried to stabilise the patient's condition by stopping inhalation of the anaesthetics and immediately dispensed with the intravenous fluids. She added that in the anaesthesia record chart, the fall in blood pressure was recorded at 15:40hours and the patients' condition deteriorated within minutes. And that all resuscitation measures were taken as fast as possible by the team.

4.73 She said the fall in BP was followed by shallow breathing, and the patient was intubated and the CPR was performed by the team. She said medication was done intravenously so as to access the central vein more efficiently. She said Adrenaline was administered in 1mg/500ml NS, because the patient's condition was initially recognised as severe hypotension rather than cardiac arrest.

4.74 She said anaphylactic reaction in such a situation could not be picked, as the signs and symptoms may have been masked under anaesthesia. She explained that what was immediately identified was cardiovascular collapse. She added that anaphylactic reaction was suspected post resuscitation as one of the possible reasons leading to the severe fall in blood pressure followed by cardiac arrest. She said the patient had cardiovascular collapse without other symptoms of anaphylaxis such as erythema, bronchospasm and rush. That in the absence of these symptoms, anaphylaxis could only be retrospectively confirmed rather immediately diagnosed.

4.75 She said that at 18:45 hours, the patient was still intubated and sedated after the operation when she was transferred to the recovery room for continuous and sufficient monitoring. She said she personally monitored the patient together with Sister Linnah Mwiche (DW4). And that at 19:00hours, Sister Linah Mwiche informed her that the Plaintiff had been twitching. She added that she prescribed Diazepam and Phenytoin to the patient.

4.76 She added that in consultation with the Plaintiff, a decision was made to transfer the patient to a facility with an intensive care unit and capable of conducting brain CT scan. She said during the process of transfer, the patient self-extubated. And that considering that the patient's vitals were stable according to the monitor, it was safer to re-intubate at the destination which was within the short distance rather than in the ambulance.

4.77 She said she addressed the Plaintiff in English and at no time, did she use a foreign language. And that she tried her best to explain to the Plaintiff in simple language.

4.78 In cross exanimation she said she noticed the problem before the Surgeon.

4.79 DW8 was Boniface Bwembya Bwalya, the first witness for the Sixth Defendant.The Registrar of the HPCZ. His testimony largely centred more on the regulatory role of the HPCZ. He stated that the role of the HPCZ was outlined in section 4(1) of the Health Professions Act, which provides:

1. ***licensing public and private health facilities accredit health services and monitor the quality control and monitor quality assurance of health facilities and services;***
2. ***develop, promote maintain and improve appropriate standards of qualifications in the health profession; and***
3. ***develop, promote and enforce internationally comparable practice standards in Zambia.***

4.80 He stated that in performing its first listed mandate, the HPCZ is guided by section 38 (1) (a) of the Act. And that a health facility that meets the requirements of the Act is issued with a licence that meets the criteria. In particular reference to a Class A Licence, reference was made to section 38(1)(a)(i), which provides:

> ***(i) Class A – for a health facility to provide in-patient care for acutely ill persons requiring regular monitoring and interventions by a medical doctor, including hospital and hospice to provide palliative care for the terminally ill; provided the Health care in the facility shall be supervised by a medical doctor;***

4.81 He added that by virtue of section 76 of the Act, the HPCZ is mandated to issue guidelines necessary to carry out the provisions of the Act. And he made reference to the Licensing of Health Facilities Guidelines of 2010 and the National Health Care Standards of 2020. He said the HPCZ did not commit breach of its statutory duty in issuing a Class A Licence to Viva Med Hospital. That even assuming that the HPCZ was in breach the Act makes no provision for recovery of damages.

4.82 DW9 was Muchenalah Chibasa, a Director Inspectorate in the employ of the HPCZ. He stated that a health facility must be inspected preceding the issuance of a licence, and at least every two (2) years by the HPCZ. He stated that the HPCZ carry out five different types of inspections. Firstly, the initial inspection, which is done upon a health facility applying for a license. He recounted that this type of inspection was carried out upon application of by Viva Med Hospital on September 27, 2013.

4.83 He said the second type carried out is termed routine compliance monitoring inspection, to ensure compliance with the requirements under section 47 (3) of the Act, and that such routine inspection were carried out on Viva Med Hospital on February 9, 2015, April 13, 2016 and September 3, 2019, respectively.

4.84 He said the third inspection was a surveillance compliance inspection, which involves random checks to ensure that a health facility complies with the health standards. He said one of such inspections was done on October 1, 2020 on Viva Med Hospital during the outbreak of the *Covid 19* pandemic.

4.85 He added that the fourth type is the supporting inspection, where a health facility requests an inspection in case of any variation of the conditions of the licence that is issued to a health facility.

4.86 He stated that the fifth type of inspection is a reactive inspection, done where there is a complaint lodged by a member of the public against a health facility. He said in that case an inspection of the health facility becomes necessary, to investigate the allegations contained in the complaint. That an inspection in this regard against Viva Med Hospital was conducted on July 16, 2021 following a complaint by the Plaintiff lodged on June 25, 2021. He said this culminated into a report dated July 16, 2021. The objective of the reactive inspection was stated to be:

4.65.1 ***To ascertain if Viva Med Hospital is not currently meeting the set standards to continue operating as a Class A Health Facility.***

4.87 And as regards classification of the facility in terms of medicine, surgery, obstetrics, gynaecology and paediatrics, it was reported that the facility met the requirement as a Class A Hospital as defined both in section 38 of the Act and in Standard 1 of the National Health Care Standards (NHCS) 2020.

4.88 And as regards referral of patients from one health facility to another, he said, it was dependent on a number of factors, which include the judgment of the medical practitioner caring for the patient.

4.89 He said the deceased's referral from Viva Med Hospital to CFB was horizontal, done between health facilities that are within

the same class. And that the transfer was instigated by the judgment of the medical practitioner responsible over the patient and not by the class ranking of Viva Med Hospital.

4.90 PW10 was Fyatilami Chirwa, a Manager for Inspections and Accreditation in the employ of the HPCZ. His testimony is materially similar to that of DW9, therefore, I shall not labour to extensively summarize the same. Save to say, he said as per the reactive inspection carried out on July 12, 2021 Viva Med Hospital had a functional consultation room, treatment room, observation room, ideal operating theatre services and impeccable in-patient services that complied with Standard 16 of the NHCS 2020. He added that Viva Med Hospital continued to meet the standards set out for a Class A Hospital.

4.91 In cross examination he stated that a CT scan is a support service which is desirable in a facility that has an ICU and that it was mandatory for some level of service based on some levels of some health facilities, were it is listed as mandatory requirement, such as Class A level 2 and level 3 health facilities.

4.92 He explained that on ICU and HDU were different and that a HDU was required for a Class A level 1 Hospital. While an ICU was required for a Class A levels 2 going upwards. According to him, a HDU is simply a room with critical care equipment, which equipment can be found in an ICU. And that the two differ also on the staff compliment that is required for both.

4.93 He said a HDU is required to be staffed by general medical doctor, while an ICU is required to be staffed at a minimum by a clinical officer with specialisation in anaesthesia or by

physician or medical doctor with training in advanced life support or accessible anaesthesiologist, who must do rounds almost every day. He added that an ICU should have a nurse in charge who is qualified in critical care, which requirement was not applicable to a HDU.

4.94 DW11 was Lupasha Mwila, a General Surgeon at the University Teaching Hospital. He stated that he was also the Chairperson for the Investigations Committee (Investigation Team) of the HPCZ, comprising of four other members, constituted pursuant to rule 5 (6) of the ***Health Professions (Disciplinary Proceedings) Rules, Statutory Instrument No. 114 of 2013(Disciplinary Proceeding Rules)***.

4.95 He said an Investigation Team was instituted to investigate allegations of professional misconduct of medical practitioners at Viva Med Hospital raised by the Plaintiff following the death of Agnes Mdala. He also stated that the complaint included the status of Viva Med Hospital, against the allegation that the Hospital operated as a Class A Hospital when it was not equipped to deal with the critical care situation that arose relating to the deceased.

4.96He stated that by letter dated July 3, 2021, the HPCZ replied to the Plaintiff's demands, stating that as far as licensing was concerned, Viva Med Hospital as a Class A health facility, it met all the requirements for holding such a licence.

4.97He stated that investigations were instituted to establish any professional misconduct on the part of medical practitioners that attended to the deceased in particular, the Second and the

Third Defendants. And that on dates between July 1st and 10th 2021, interviews were conducted on medical personnel from Viva Med Hospital and Care For Business Medical Hospital, culminating in a Preliminary Investigation Report.

4.98 He added that medical records were also reviewed from both hospitals which culminated in an Anaesthesiologist and Intensivist Care Report. He said before investigations were concluded and recommendations made, the Plaintiff instituted the present action. That notwithstanding court proceedings the HPCZ proceeded to attend to allegations against Viva Med Hospital, culminating in an inspection report dated July 16, 2021 which revealed that the Hospital met the criteria of a Class A Health Facility as required by section 38 of the Act and the National Health Care Standards of 2020.

4.99 He stated that as a result of court proceedings herein, the HPCZ did not interview the Plaintiff. And that further investigations or recommendations against the Second and the Third Defendants were dependent on the outcome of this case.

5.0 THE PLAINTIFF'S SUBMISSION

5.1 The Plaintiff's Counsel in alleging negligence against the First to the Fifth Defendants noted that the perspective of negligence was twofold. Firstly, from the surgical perspective. And secondly, from the anaesthesiological and intensive care perspective.

5.2 And as to the applicable test of negligence in medical cases reference was made to the case of ***Bolam Friern Hospital Management Committee***[1] wherein Mc Nair J., stated:

5.2.1 ***Where you get a situation, which involves the use of some special skill or competence the test is the standard of the ordinary man exercising an professing to have the special skill. A man needs not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art... in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time.***

5.3 He noted that the expert report by Dr. Mutumba Songiso focused on acts and omissions of Dr. Akhtaev, whereas the expert report of PW3 Dr. Niza Sheyo focused on Dr. Khajimatova's acts and omissions. It was submitted that the negligence pleaded by the Plaintiff was substantiated by the evidence in the expert reports. That the First and Second Defendants failed to act in accordance with the standard of ordinary competent surgeons before, during and after the surgery.

5.4 It was contended that, the Second and the Third Defendants failed to act in accordance with the standard of ordinary competent surgeon and anaesthesiologist before, during and after the surgery. It was reiterated that the reports highlight the actions and omissions of the First to Fifth Defendants.

5.5 On the issue of medical advice given to the deceased, it was argued that, the late Agnes Mdala was negligently advised. That she was not warned of the possible risk of cardiac arrest, anaphylactic shock and death. In reference to the English case of ***Chester v Afsher***[2] it was submitted that, the Court of Appeal held that, the failure of a medical professional to warn the

patient of the risk of surgery amounted to causation in negligence. It was held:

5.5.1 ***Where a doctor should be held to have caused the injury, the risk of which he failed to give proper warning to his patient.... The relevant law on the duty to warn is controversial... Effectively this claim has been pursued on the basis that the appropriate test to apply to the defendant's conduct was the well-known test enunciated by McNair J in*** *Bolam v Friern Hospital Management Committee (19570 1 WLR 582* ***and approved by the House of Lords in*** *Sideway v Bethlem Royal Hospital Governors [1985] 1 All ER 643,* ***[1985] 1 AC 871.***
In Sideway's Case Lord Bridge of Harwich said...that when questioned by a patient of apparently sound mind about risks involved in a particular treatment proposed the doctor's duty must be to answer both as truthfully and as fully as the questions requires. That case concerned a laminectomy operation and Lord Templeman said ... that if the plaintiff concerned had asked questions about this operation she could and should have been informed that there was an aggregate risk of between one per cent and two per cent risk of some damage either to the spinal cord or to a nerve root resulting in some injury which might vary from irritation to paralysis.
It was common ground at the trial that the defendant in accordance with good medical practice should have warned the claimant of the risk of damage involved in the light of the questions she asked, and the observations of Lord Bridge and Lord Templeman in Sideway's case., she should have been fully told what the risk was....
The purpose of the rule requiring doctors to give appropriate information to their patients is to enable the patient to exercise her right to choose whether or not to have the particular operation to which she is asked to give her consent. English law has rejected the proposition that the failure to give adequate warning vitiates the patient's consent, thus turning the operation into an assault (see *Chatterton v Gerson [1981]*

1 All ER 257 (1981) QB 432). ***Liability lies in negligence rather than trespass/ but the patient does still have the right to choose what will and will not be done with her body and the doctor must take care expected of a reasonable doctor in the circumstances in giving her the information relevant to that choice. The law is designed to require doctors properly to inform their patients of the risk attendant on their treatment and to answer questions put to them as to that treatment and its dangers, such answers to be judged in the context of good professional practice, which has tended to a greater degree of autonomy. The object is to enable the patient to decide whether or not to run the risk of having that operation at that time. If the doctor's failure to take that care results in her consenting to an operation to which she would not otherwise have given her consent, the purpose of that rule would be thwarted if he were not to be held responsible when the very risk about which he failed to warn her materialise and cause her an injury which she would not have suffered then and there.***

5.6 It was also argued that the consent form, which the deceased never signed in the first place, did not list the risks of surgery.

5.7 It was submitted that the risk of what actually happened, the deceased was never warned, including the risk of the operation being fatal. It was observed that in Zambia the duty to warn of the possible risks was cemented by the Patient's Charter, which provides:

5.7.1 ***iv) to receive from the patient's health practitioner(s) or other clinical practitioner(s) an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives in terms that the patient understands. If this information shall be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to his or her next of kin***

or guardian and be documented in the patient's medical record.

5.8 It was argued that, if the deceased chose something that was against the advice of the First and the Second Defendants, the Second Defendant ought to have recorded this in his notes. According to Counsel, the deceased did not choose lumpectomy. He added that if the deceased was properly advised she would not have gone for lumpectomy. And if properly advised, as per the testimony of her husband and her sister, PW1 and PW4 respectively, she would have gone for the alternative option of core needle biopsy.

5.9 It was argued that the First and the Second Defendants are liable for conducting surgery without the consent of the deceased.

5.10 It was argued that the suffering and death occasioned to the deceased was as a result of the Defendants, and this speaks for itself. The case of ***Ndola Central Hospital Board of Management v Alfred Kaluba***[3] was cited regarding the principle of *res ipsa loquitur*.

5.11 And as regards the alleged liability of the Sixth Defendant, HPCZ, it was argued that the liability of the First to the Fifth Defendants was linked to the liability of the Sixth Defendant.

5.12 And relying on the case of ***X and Others v Bedfordshire CC, M (a minor) v Newham London BC, E (a minor) v Dorset CC***[4], it was submitted that if parliament has imposed a statutory duty on a public body, a plaintiff who has suffered damages as a

result of the performance or non-performance of that function, has a right in damages.

5.13 Accordingly, Counsel highlighted the functions of the HPCZ as provided under section 4 of the Health Professions Act:

> ***4. (1) The functions of the Council are to—***
> ***(a) register members of the health profession and regulate the professional conduct of health practitioners;***
> ***(b) maintain appropriate practice standards among health practitioners that are consistent with the principle of self-regulation and the promotion of high standards of public health;***
> ***(c) develop, promote, maintain and improve appropriate standards of qualification in the health profession;***
> ***(d) promote the integrity, and enhance the status, of the health profession including the declaration of any particular health practise to be undesirable for all, or a particular category of, health practitioners;***
> ***(e) licence public and private health facilities, accredit health services and monitor quality control and assurance of health facilities and services;***
> ***(f) represent, coordinate and develop the health profession and promote its interest;***
> ***(g) develop, promote and enforce internationally comparable practice standards in Zambia;***
> ***(h) investigate allegations of professional misconduct and impose such sanctions as may be necessary;***
> ***(i) protect and assist the public in all matters relating to the practice of the health profession.***

5.14 It was argued that Viva Med Hospital was carelessly licensed as a Class A Health Facility, because it was incapable of providing in-patient care to the Late Mrs. Mdala, who became critically ill under the charge of the First to the Fifth Defendants.

5.15 It was argued that it was evident that Viva Med Hospital did not have an ICU, an essential requisite facility for a Class A health facility. It was submitted that a health facility should not perform procedures that it would not be able to contain when complication arise.

5.16 It was Counsel's contention that the HPCZ was careless in its duty to the Plaintiff to maintain and enforce practice standards, and failed to enforce necessary sanctions. According to Counsel, the HPCZ had no systems in place to ensure that its professionals and hospitals it regulates give meaning to the Patient's Charter.

5.17 I was thus urged to grant the relief's sought.

6.0 DEFENDANTS' ARGUMENTS

6.1 In rebuttal, Counsel for the First to the Fifth Defendants adopted the *Bolam* test principles enunciated in the ***Bolam*** case. In Counsel's understanding of the *Bolam* test, it was argued that, if a medical practitioner acts in accordance with the standard practice of a responsible medical opinion, then he/she is not negligent despite contra medical evidence. According to Counsel, this illustrates the protection accorded to medical practitioners who apply standards practice in demanding scenarios yet may not successfully treat the patient. In Counsel's words, he submitted that: *This highlights that tragic outcome, even if avoidable, may not be negligence.*

6.2 The opinion of PW3 was described as wanting for lack of objectivity and highly questionable. Counsel in detail specifically responded to the issues of alleged negligence item

by item based on evidence. And the Court was reminded that to find the First to the Fifth Defendants liable, causation must be proved that they triggered or influenced the patient's damage. That based on the evidence, what was established is the fact that the patient's cause of death remained curiously and mysteriously unknown.

6.3 It was argued that the lack of a post-mortem examination compounded the doubt as regards the cause of death. That without the post-mortem examination, it was impossible for the Court to make a determination on whether the hurdle of causation was overcome.

6.4 Causation was also considered in the light of the ***Chester*** case. Counsel noted that the applicability of the case was novel in our jurisdiction. It was observed that the case was a complete departure from the normal rule of causation. That instead of establishing a causal link between the alleged breaches by the Defendants and the death of the patient, and the damage suffered being foreseeable, the ***Chester*** case or principle seeks to penalize the Defendants for supposedly not informing the patient of all the risks associated with the procedure regardless of whether it was caused by the Defendants or not.

6.5 As regards the principle of remoteness of damage, Counsel, cited the old celebrated case of ***Re Wagon Mound***[5] wherein the Privy Council stated:

6.5.1 ***It is a principal of civil liability... that a man must be considered to be responsible for the probable consequence of his act. To demand more of him is too harsh a rule.***

6.6 It was argued that there was no compulsion to adopt the ***Chester*** case. The case of ***Nyimba Investments Limited v Nico Insurance Zambia Limited***[6] were vouched in which the Supreme Court held:

6.6.1 ***While authorities of apex courts in England will remain persuasive on this court, we shall not apply them without consideration of the circumstances in which they were decided.***

6.7 And in dissuading the Court not to adopt the ***Chester*** case, it was observed that, the case was decided on the narrowest majority of 3 to 2 in the House of Lords. It was noted that in the dissent judgment, there was strong opposition to the departure of the normal principle of causation through what he termed abolishment of the "but for" test. Lord Bingham's dissent was quoted as follows:

6.7.1 ***The ordinary run of cases satisfying the "but for" test is a necessary if not a sufficient condition of establishing causation. Here, in my opinion, it is not satisfied. Miss Chester has not established that but for the failure to warn she would not have undergone surgery. She has shown that but for the failure to warn she would not have consented to surgery on Monday 21 November 1994. But the timing of the operation is irrelevant to the injury she suffered, for which she claims to be compensated. That injury would have been as liable to occur whenever the surgery was performed and whoever performed it.***

6.8 It was submitted that the principle would be onerous on medical practice and the courts would be able to find a medical practitioner casually responsible, despite the absence of actual evidence of a causal link. Thereby making it relatively easy for claimants to institute all sorts of court proceedings for all

manner of damages without any evidence, but successful by merely saying: *If I had been warned I would have taken time to decide.*

6.9 And the fears of easing the availability of claims against medical practitioners was voiced through remarks expressed in the case of ***Roe v Ministry of Health***[7] thus:

6.9.1 ***We realise that health care providers fear that if the courts are tolerant of medical negligence claims, many more disaffected patients may be inclined, driven by a diversity of reasons, to sue for negligence which in turn will raise the cost of medical services, and induce physicians to practice defensive medicine, with all its attendant costs in professional attention and resources.***

6.10 It was further submitted that it was clear from the testimonies of DW5, the Second and the Fourth Defendants that the consent form was in fact signed by the patient in her full knowledge and presence of mind. That she personally affixed her name at the bottom of the consent form to indicate she agreed with the contents thereof. That the fact that her signature appears nowhere next to her name did not take away from the fact that the patient freely attended to the operation.

6.11 All in all, I was urged to dismiss the claims, because the Plaintiff failed to discharge the burden that the First to the Fifth Defendants' professional conduct fell below the standard of an ordinary skilled man professing to have that special skill.

6.12 I now turn to arguments by HPCZ. Counsel for HPCZ Mr. Mulenga from the onset argued that there was no proof that HPCZ was in breach of statutory duty in terms of accreditation

of Viva Med Hospital as a Class A Health Facility. That in terms of section 38(1)(a) of the Health Professions Act, Viva Med Hospital was licenced to provide in-patient care for an acutely ill person requiring regular monitoring and intervention by a medical doctor. It was added that there was no breach of statutory duty as regards investigating the Plaintiff's complaint.

6.13 It was submitted that the Plaintiff was supposed to adduce evidence to show which equipment Viva Med Hospital did not have which would have warranted and proved it wrong for the HPCZ to accredit Viva Med Hospital as a Class A Health Facility. And that as per PW2's expert report, he admitted that the HPCZ was in a better position to determine the scope of services that Viva Med Hospital could offer as a health facility.

6.14 In reference to the HPCZ's witnesses it was submitted that Viva Med Hospital had all the requisite equipments and facilities that a Class A hospital should have. And restated for emphasis that Viva Med Hospital met the criteria under section 38 (1) (a) of the Act, for provision of health care services such as medicine, obstetrics, surgery, gynaecology and paediatrics.

6.15 And as regards the Plaintiff's allegation that the HPCZ failed to take action or steps to actualize the rights of the deceased. It was rejoined that the Plaintiff had failed to appreciate the difference between licensing and, enforcement of a patient's rights, following the lodgement of a complaint with the HPCZ. It was contended that the HPCZ carried out its mandate to investigate the alleged violations of the deceased's rights and alleged professional misconduct of the health practitioners

involved, except the investigations were halted following the Plaintiff taking out the present action. Thus, section 2(1) of the ***Contempt of Court (Miscellaneous Provisions) Act, Chapter 38 of the Laws of Zambia*** was vouched to justify the cessation of investigations. The same section provides:

6.15.1 ***2.(1) A person shall not be guilty of contempt of court on the ground that he has published any matter calculated to interfere with the course of justice in connection with any proceedings or imminent at the time of publication if at that time (having taken all reasonable care) he did not know and had no reason to suspect that the proceedings were pending, or that such proceedings were imminent, as the case may be.***

5.16. I was urged to dismiss the Plaintiff's claims against the HPCZ.

7.0 SUBMISSIONS IN REPLY

7.1 In reply, and in particular reaction to the First - Fifth Defendants' contention on the Plaintiff's reliance on the ***Chester*** case to the effect that the same is novel and ought not to be followed, it was submitted that the position taken by the Defendants was unfortunate. That this sort of argument was debunked in ***Parker v Parker***[8] wherein Lord Denning LJ remarked as follows:

7.1.1 ***What is the argument on the other side? Only this, that no case has been found in which it has been done before. That argument does not appeal to me in the least. If we never do anything which has not been done before, we shall never get anywhere. The law will stand still while the rest of the world goes on, and that will be bad for both.***

7.2 It was argued that the ***Chester*** case was not a departure from established principle of causation. And that Sir Dennis Henry accepted the use of the "but for" test, but noted that the same had deficiencies because it is not always possible to establish causation in law. Additionally, it was contended that the Defendants' floodgate fear was unfounded.

7.3 And as regards the submissions by HPCZ, it was rejoined that, notwithstanding the fact that the Health Professions Act did not expressly provide for damages, the Plaintiff was entitled to damages. It was reiterated that there was sufficient evidence of breach of statutory duty based on the evidence of Dr. Songiso and Dr. Sheyo, not least the testimony of the Plaintiff. It was reiterated that the HPCZ failed to properly licence Viva Med Hospital and failed to conclusively investigate the allegations of professional misconduct.

7.4 Finally, it was argued that the HPCZ had misconstrued the application of contempt of court, and described the misapprehension as: *clearly grasping at straws*. It was contended that investigating the Plaintiff's complaint and publishing its investigations was not in any way intended to interfere with the course of justice, but aid the course of justice.

7.5 Once again I was implored to grant the Plaintiff's claims, including the grant of a mandatory injunction to compel the HPCZ to comply with its statutory obligations.

8.0 DETERMINATION

8.1 I took the liberty to significantly give a summary of the evidence and key snippets of spirited arguments to demonstrate that I have carefully considered the evidence and the arguments thereof. The facts not in dispute as earlier stated are reaffirmed. And for the avoidance of doubt the Plaintiff was the husband to the late Agnes Lucia Kaluzi Mdala. And Viva Med Hospital was at the material time a private hospital providing medical services and care to members of the general public. The Second to the Fifth Defendants were health practitioners who directly dealt with Mrs. Mdala on December 18, 2020 when she was scheduled for lumpectomy procedure.

8.2 It is common cause that Mrs. Mdala, sometime in October, 2020 discovered a lump in her breast. And that on October 28, 2020 she visited Viva Med Hospital, and had medical audience with Dr. Muparrakh, who upon examination confirmed the presence of a lump in her breast. And antibiotics were prescribed for her, hoping that the lump would shrink with the said medication. But on December 2, 2020 when Mrs. Mdala returned to Viva Med Hospital for review, it was discovered that the lump was still the same and had not shrunk. An appointment was then secured on December 4, 2020 with the Second Defendant, the Surgeon Dr. Akhta Akhtaev.

8.3 On December 4, Mrs. Mdala met with the Second Defendant for consultation. And after consultation and discussions, between the Surgeon and Mrs. Mdala, lumpectomy procedure was

arrived at rather than core needle biopsy. And a date scheduled for the operation was December 18, 2020.

8.4 I am satisfied that on the scheduled date for the operation, a routine preoperation Check List was done by Dr. Dildora Khajiamatova to ascertain Mrs. Mdala's allergies. And she disclosed that she was allergic to Tilipia fish, game meat (buffalo) and Tramadol, a painkiller.

8.5 On December 18, 2020 as scheduled, Mrs. Mdala went into operation for lumpectomy at around 15:20 hours under general anesthesia. And while the surgical operation was in progress to remove the lump, the operation suffered some setback. Notably, 10 minutes into the process of removing the lump, Mrs. Mdala suffered profound hypotension followed by cardiac arrest. And a retrospective review of the process revealed that Mrs. Mdala had suffered anaphylactic shock associated with the anesthetics drugs.

8.7 It is probable that that anaphylaxis could not be detected or determined at the time by the Surgeon or/and by the Anesthetist because, the same was masked due to the fact that the patient was under general anesthesia, and the same could only be determined retrospectively. It is also probable that this could have been the reason why, the Plaintiff was not immediately and conclusively told that his wife had suffered a cardiac arrest.

8.8 Since the procedure was halfway done, when Mrs. Mdala suffered anaphylaxis, but resuscitated, the lumpectomy procedure was resumed and concluded, and the wound was

sutured. However, the deceased never regained consciousness and had to be transferred to CFB where she was admitted to the Intensive Care Unit,where her health deteriorated further and she died on December 23, 2020.

8.9 Therefore, the question begs, regarding the pith and substance of this case; whether the death of the deceased was primarily caused by the negligence of the First to the Fifth Defendants.

8.10 At the outset it is unavoidable from a moral point of view to say the deceased met her death in a very untimely manner. As rightly pointed out by the Plaintiff, the health of the deceased on that material day was generally good, both mentally and physically. Her vitals were checked and were found to be within the normal ranges. What was expected to be an ordinary and normal procedure turned out to be fatal, and inflicted unbearable pain and misery to the Plaintiff and Mrs. Mdala's family.

8.11 The question of liability particularly of medical negligence is not only a factual one, but also a legal one. In order to prove medical negligence like any other professional negligence, three key ingredients of negligence fall for determination: (a)proof of the duty of care, (b) breach of the duty of care and (c) proof of resultant injury arising from the breach of the duty of care.

8.12 In providing legal illumination to the above principles, Lord Denning M.R. in the case of ***Roe v Ministry of Health and Others***(supra) had this to submit:

8.12.1 ***The first question in every case in whether there was a duty of care owed to the Plaintiff, and the test of***

duty depends, without doubt, on what you should foresee. There is no duty of care owed to a person when you could not reasonably foresee that he might be injured by your conduct.... The second question is whether the neglect of duty was a cause" of the injury in the proper sense of the term and causation, as well as duty, often depends on what you should foresee. The chain of causation is broken when there is an intervening action which you could not reasonably be expected to foresee.

8.13 It is a settled principle of law as stated in the case of ***Edna Nyasulu v Attorney General***[9] that in a doctor-patient professional relationship, a medical doctor owes a duty of care to a patient, and when breached will result in his or her liability to the patient.

8.14 Furthermore, the learned authors, Margret Brazier and Emma Cave in their book entitled: ***Medicine, Patients and the Law 4th Edition***(Nexis Lexis: Butterworths, 2007) at page 156, submit that:

8.14.1 ***A hospital and its entire staff owe a duty to patients admitted for treatment.***

8.15 Clearly, when a medical practitioner is entrusted with the professional duty of providing medical services and care to a patient, the trust of the patient must be reciprocated by the required duty of care that is professionally acceptable. And once the mantle of that duty of care is performed below its required standard, the medical practitioner will be held accountable. However, that is not to say, that every unsuccessful medical procedure faithfully carried out by a heath practitioner attracts liability against that medical practitioner. I reckon it is realistically acceptable that a medical procedure may not go well

despite its well structured plan, perhaps due to unforeseen intervening circumstances.

8.16 As to the standard of medical care that may be used to vitiate medical negligence or used to find the practitioner liable, the Supreme Court in concurrence to the ***Bolam*** case had an opportunity to consider this in the case of ***Rosemary Bwalya v Zambia Consolidated Copper Mines Limited (Mufulira Division) Malcolm Watson Hospital and Dr. Y.C. Malik***[10], wherein it held:

8.16.1 ***(1) the standard of care demanded of medical practitioners is the standard of the ordinary skilled man exercising and professing to have that special skill.***

(2) A medical practitioner need not profess the highest expert skill. It is sufficient if he exercises the ordinary skill of a competent person exercising the ordinary skill of a competent person exercising that particular art. The art is judged in the light of the practitioner's specialty.

(3) in determining whether a defendant practitioner has fallen below the required standard of care, the law looks to responsible medical opinion. A practitioner who acts in conformity with an accepted, approved and current practice is not negligent.

8.17 I should add that where a professional is accused of negligence by the client or patient as the case may be, the applicable or expected standard of skill and care is invariably judged on the merits of each particular case. Comparably, in the South African case of ***Buls v Tsatsarolakis***[11], the Court, drew invaluable insights from the expected standard of skill and care of a surgeon by stating:

8.17.1 ***We must place ourselves in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently. Did he act as an average surgeon as someone placed in similar circumstances or did he manifestly fall short of the skill, care and judgment of the average surgeon in similar circumstances? If he falls short, he is negligent.***

8.18 There is certainly no doubt that the First to the Sixth Defendants owed the deceased a duty of care. Starting with the Sixth Defendant (HPCZ), the Sixth Defendant's duty was to ensure that its statutory obligation was met by regulating Viva Med Hospital and its medical personnel, and ensure that they had the necessary facilities to meet the standard of a Class A Hospital. And Viva Med had a duty of care to ensure that it had facilities in place as well as health practitioners that were qualified in the areas of medicine, obstetrics, gynecology, pediatrics and in particular, surgery.

8.19 There is no doubt that the health practitioners contracted by Viva Med Hospital, in particular and primarily, the Second and Third Defendants, as medical doctors were respectively licensed, qualified and competent to deal with the deceased's medical procedure.

8.20 The crucial issue to determine is whether the Second and the Third Defendant negligently caused the death of the deceased. And the standard to be applied is whether their professional performance was reasonable or short of the skill, care and judgment of an average specialist in their particular fields.

8.21 In the present case, the deceased was directly handled by the Second to the Fifth Defendants, being health practitioners at Viva Med Hospital. And as earlier noted the deceased had a lump in her breast and sought medical care from the Hospital. And the remedial measure in terms of permanent solution, as it were, was explained to her by the Second Defendant, Dr. Akhtaev. Two options were available, lumpectomy or core needle biopsy. The procedure that was agreed upon was lumpectomy. This option was inspired by the fact that, it was the desire of the deceased and in concurrence with the discretion of the Surgeon to deal with the situation once and for all rather than to go for a core needle biopsy, which meant harvesting a part of the lump and subjecting the same to laboratory examinations.

8.22 It was contended by the Plaintiff's Counsel that the deceased was negligently advised in the sense that she was not warned of the possible risk of cardiac arrest, anaphylactic shock and death. That had she been told of these risks, she would not have settled for lumpectomy.

8.23 While it is generally stated that every surgical procedure involves an inherent risk of fatality, the evidence on the record shows that the risk of death in lumpectomy *per se,* is transcendently remote. I find it plausible that Dr Akhtaev not only did he explain the available options vis-à-vis lumpectomy verses core needle biopsy, he also explained the possible complications. It is, therefore, unsurprisingly that the apparent dominant concern of the deceased at that material time was keloid. Additionally, the deceased was settled that no Tramadol would be used, after she disclosed that she was allergic to

Tramadol. Even the type of anesthesia to be applied was discussed.

8.24 I am satisfied that the Surgeon, Dr. Akhtaev reasonably explained the lumpectomy procedure and the deceased being a health conscious person elected to go for lumpectomy, because it was a one step procedure. And prior events leading to the deceased's elective decision speak for themselves. It was not her debut appearance on December 18, 2020. The deceased on a number of occasions consulted with Viva Med Hospital about her condition. Tests were conducted and diagnosis of a lump in her breast was confirmed, and medical remedies availed. The first was by use of antibiotics to try and reduce the size of the lump on the belief that the same would disappear or shrink, and avoid blocking the milk duct considering that she was breast feeding at the time.

8.25 Secondly, when the lump did not reduce or disappear, further tests were done, revealing that the lump was still the same and at this point, the deceased was then referred to the Second Defendant. The record is also clear through the testimonies of the Plaintiff and PW4 that after her discussion with the second Defendant, the deceased conducted her own research regarding lumpectomy procedure, and was comfortable to go for lumpectomy, because the risk of death was negligible.

8.26 It is also worth noting that the deceased did not approach Viva Med Hospital because, she was worried about the lump being cancerous, her complaint was the presence of the lump in her breast. And her clear desire was to have it removed.

8.27 While it is not in doubt that the lumpectomy procedure is usually an elective surgery, so to speak, it was contended that the patient (deceased) did not consent to the operation because, the consent form bears no signature of the deceased. The South African case of ***Castell v De Greef***[12] highlights the principle behind a patient's consent to surgery. In that case, it was held:

8.27.1 ***It is clearly for the patient in the exercise of his or her fundamental right to self-determination, to decide whether he or she wishes to undergo the operation and it is in principle wholly irrelevant that the patient's attitude is grossly unreasonable in the eye of the medical profession; the patients right to bodily integrity and autonomous moral agency entitles him or her to refuse medical treatment.***

8.28 In addition to what I have stated above, it is my considered opinion that the deceased consented to lumpectomy. The argument that she did not consent is improbable. And it is unthinkable to suggest that the Surgeon forced the procedure on the deceased or exerted undue influence to induce the deceased to accept the procedure. The deceased wrote down her name on the consent form indicating that she understood the contents of the consent form. And the writing of her name was not in anyway disputed by the Plaintiff. I agree with the argument by the First to the Fifth Defendants' Advocates that the deceased freely and with her right mind participated in the lumpectomy procedure, after options were made available to her.

8.29 Therefore, in the light of these facts, the principle set out in the ***Chester*** case is strikingly distinguishable from the present case, and inapplicable, particularly that in the present case, the

patient is deceased, and the issue of consent is deciphered through third parties giving irreconcilable positions depending on the side of the dispute. Whereas in the ***Chester*** case, the issue of consent or want thereof was direct from the patient, in the present case it is not the case.

8.30 In the ***Chester*** case, as rightly hinted by Counsel for the First and Fifth Defendants, Ms. Chester, directly spoke to the condition of her mind whether she consented or not, or whether she was warned or not regarding the risks associated with her surgery.

8.31 The application of the ***Chester*** principle cannot be *carte blanche*. I equally relish the idea of allowing the law to evolve. However, I conscientiously agree with the First to the Fifth Defendants' Counsel that in giving space for the law to evolve, particularly by borrowing trending principles from other Commonwealth jurisdictions, departure from settled principles of law in our jurisdiction should only be done under compelling circumstances.

8.32 Generally, in the application of common law to our jurisdiction as it evolves in other Commonwealth jurisdictions, I bear in mind the caution sounded by the Supreme Court in the case of ***Nyimba Investments Limited*** (supra) and I desire to add the case of ***Nyali v the Attorney General***[13] in which Lord Denning guided that:

8.32.1 ***The common law cannot be applied in foreign lands without considerable qualification. Just like an oak tree, so with English common law. You cannot***

transplant it to the African continent and expect it to retain the character which it has in England.

8.33 Therefore, I discern no compelling justification or special circumstances to abandon the "but for" test or, contextually modify it in line with the majority decision of the ***Chester*** case, when the apex court in our jurisdiction still religiously applies the "but for" test. Therefore, I recall what the Supreme Court stated in ***Match Corporation Limited v Development Bank Zambia and Another***[14] that:

8.33.1 ***Again in*** *Kasote v. the People (1977) Z.R.75* ***, this Court not only affirmed the importance of the principles of stare decisis to a hierarchical system of Court (whereby lower Courts are bound to follow the latest of any superior Courts decision on a point) but also affirmed that being the final Court in Zambia this Court adopts the practice of the House of Lords in England concerning previous decisions of its own and will decide first whether in its view the previous case was wrongly decided and, secondly, if so, whether there is a sufficiently strong reason to decline to follow it. Again in*** *Abel Banda v the people (1986) Z.R. 105,* ***this Court had to resolve which of the two conflicting decisions represented good law and having made that choice we had to consider the principles of stare decisis. We had this to say at page 114:***

The problem before us therefore is that we have made case law which we have realized is indefensible. The principle of stare decisis requires that a court should abide by its ratio decidendi in past cases. Put simplicity in order to have certainty in the law decisions of courts should be consistent and should not be readily changeable as to make it at any given time what the law is on a given issue. In order to uphold this principle therefore past decisions should not be exploded for the sole reason that they are

wrong. Courts should stand by their decisions even if they are erroneous unless there be sufficiently strong reason requiring that such decisions should be overruled.

8.34 Having crucially dealt with the preoperation issues, I now turn to determine how the operation itself was conducted, whether negligently or not.

8.35 Lumpectomy is a medically recognised remedial procedure that can be carried out on a patient who has a lump in her breast. Dr. Akhtaev had abundant skill and expertise to carry out the lumpectomy procedure. There is nothing to show on the record that the procedure was performed below the standard of an ordinary skilled specialist, professing to have the same skills set of a surgeon. In fact, this was somewhat confirmed by Dr. Mutumba Songiso in his expert report where he opined that:

8.35.1 ***After reviewing all the documents presented to me, I am of the view that the events which led to the death of the deceased may have not been directly because of the surgeon's incompetence in performing the surgical operation.***

8.36 It appears the bulk of medical negligence hinges on the skill and care of the Cardiac Anaesthesiologist, the Third Defendant, Dr. Dildora Khajimatova. This is because the deceased is reported to have suffered anaphylaxis, due to anaesthetic drugs, thereby resulting in cardiac arrest.

8.37 The bulk of opinion evidence that attacks the manner in which Dr. Khajimatova conducted the anaesthesia and responded to the deceased's condition of anaphylaxis came from the opinion of PW2, Dr. Niza Sheyo. The opinion of Dr. Sheyo was solely

based on his desk research of medical documents that were availed to him from Viva Med Hospital and CFB.

8.38 The anaesthesia that was administered to the deceased is one that is called general anaesthesia, i.e., the patient was wholesomely unconscious or put to sleep. There was a suggestion by PW4, the sister to the deceased, that local anaesthesia should have been preferred, however, there is nothing to medically suggest that the administration of general anaesthesia was inimical to the patient, or that it was known beforehand that the deceased was allergic to general anaesthesia. In fact, through the testimony of PW4, the deceased is reported to have said that given the location of the lump, general anaesthesia was ideal.

8.39 Upon judicial assessment of the performance and the conduct of Dr. Khajimatova, based on the evidence adduced, I am in no doubt that her professional conduct in terms of skill and care before, during and after the operation was within the reasonable standards of a reasonably informed Consultant Cardiac Anaesthesiologist.

8.40 The medical team comprising the Surgeon, the Anaesthetist and Dr. Musaeva who was on hand to help her colleagues never abandoned the deceased. They did everything professionally possible within the bounds of their medical practice to remedy the unforeseen turn of events. Their efforts momentarily yielded some results by offering cardiopulmonary resuscitation. The Anaesthetist directed the administration of medication, thus, Diazepam and later Phenytoin to contain the patient's seizures.

This attempt to arrest the seizures by the medical team was still in the vocation of offering medical relief to the patient.

8.41 And when the real limitations at Viva Med Hospital were experienced in terms of ICU services and a CT scan, a decision was made to transfer the patient to CFB Hospital. Again, the Third Defendant and Dr. Museava never abandoned the deceased, but accompanied her to CFB Hospital.

8.42 On the issue of transfer to CFB, it was contended that the transfer of the deceased to a facility with an ICU post cardiac arrest was negligent on the part of the First, Second and Third Defendants. According to the Plaintiff and his witness, PW3, the patient was kept for another four hours. However, I agree with Counsel for the First to Fifth Defendants that the transfer of the deceased was within reasonable time, because it was done within a twelve (12) hour time frame, which is generally the window period allowable within good medical practice. And as rightly observed by Counsel, there was general consensus that the period of transfer was not negligent.

8.43 Aside the facts of the case in terms of what happened; relating to preoperation events, during operation and post-operation, there is conflicting expert opinion. On the Plaintiff's side, the experts were PW2, Dr. Songiso and PW3, Dr. Sheyo and, on the Defendant's side the experts were DW1, Dr. Penius Tembo and DW2, Dr. Feruza Ismailova.

8.44 As regards the legal status of these opinions, the Supreme Court in the case of ***Fawaz and Chelelwa v the People***[15] ably guided as follows:

8.44.1 ***When dealing with the evidence of an expert witness, a court should always bear in mind that the opinion of an expert is his own opinion only and it is the duty of the court to come to its own conclusion based on the findings of the expert witness.***

8.45 It is for this reason that in the case cited by Counsel for the First to the Fifth Defendants, in ***Attorney General v Rosemary Mulenga***[16], courts are urged to be cautious as regards the risk of bias of hired expert witness. The Court guided as follows:

8.45.1 ***Suffice to add that while expert testimony is necessary in negligence claims, there are also dangers in overreliance on medical experts selected paid and prepared for trial by the parties. There is the obvious risk of bias and lack of objectivity and the danger that the outcome of the cases may too often depend on the expert's success in promoting their client's side, rather than in objectively educating the trier of facts and facilitating a just resolution of the matter.***

8.46 I anxiously read the expert reports by PW2 and PW3. I reckon the standard of professional skill and care professed by them generally appears to be a standard that is absolutely perfect, rather than the standard of an ordinary skilled medical professional in the fields in question herein. It is not far-fetched to reasonably fathom the object of those findings, thus, to strictly find the Defendants wanting. It is for this reason that justice demands that the trier of facts exercises his or her discretion or judgment judiciously and judicially upon careful consideration of the facts and the law in issue.

8.47 The medical team in the present case were dealing with a real life situation that required real time judgment. And the standard of judgment to be applied to measure their medical

performance or practice is relative to the prevailing circumstances at the material time.

8.48 Therefore, DW1, Dr. Tembo realistically hinted that there are no hard and fast rules, the emergency situation required real time judgment, within the acceptable bounds. Indeed, for instance, whereas, PW3 said to deal with the situation of anaphylaxis, the Anaesthetist should have recommended the administration of an injection of a bolus of Adrenaline. The opinion of the other expert witnesses called by the defence, in particular DW2 was that the quantum of the medication applied by Dr Khajimatova of 1mg/500ml was sufficient, and that a bolus of Adrenaline was not required. Dr. Khajimatova justified this approach and dosage by stating that, what was detected at the time the said dosage of Adrenaline was administered was severe hypotension, rather than cardiac arrest.

8.48 In my opinion, there was nothing shockingly negligent as regards the quantum of Adrenaline that should have been administered to the deceased to deal with her hypotension under the circumstances of the case.

8.50 Additionally, there is no evidence on the record to suggest or support the allegation that the cardiac arrest resuscitation process was negligently done because, even PW3, the expert witness called by the Plaintiff, when cross examined on this issue magnanimously stated that he needed to have been present in the theatre to come to the conclusion that the resuscitation was negligently done.

8.51 On the issue that the WHO Checklist was not done as per the required standard. While it is recommended that all procedures pre-surgery, during and post-surgery should be recorded, as per the requirement of the ***Professional Code of Ethics and Discipline: Fitness to Practice 2014*** at Clause 5.1 (c) (iv), in the present case, as per the testimony of DW2, the checklist was a mandatory requirement to be done in order to implement the standard protocols by the whole team; to ensure safety of the patient and care applied. However, DW2 added that it was not mandatory to document the same. This assertion was also corroborated by Dr. Penius Tembo, DW1. And was confirmed by Dr. Mutumba Songiso, who during cross examination indicated that there was no authority that required that a checklist should be documented.

8.52I am mindful that the deceased did not die at Viva Med Hospital, but died after a couple of days after her admission to CFB Hospital. Noticeably, no post-mortem examination was conducted to confirm the cause of death. Although, a post-mortem examination may not be a mandatory requirement for proof of medical negligence, where death occurs, it may be key in some particular cases to ascertain whether the patient died from over dosage of the administered medicine or not. For instance, in the case of the ***Attorney General v Mwanza and Another***[17], the Court was assisted by medical findings of a post-mortem examination report, to find a nurse medically liable for negligence for injecting two female patients, who later died, by medication that contained an organic-chlorine pesticide, endosulfan.

8.53 Additionally, there is nothing to suggest that administration of anaesthetic drugs in quantities of Propofol 100mg, Fentanyl 25mcg and Ketamine 50mg was foreseeable to be fatal to the deceased. Furthermore, a sample of Propofol was submitted to the Food and Drugs Laboratory at the Ministry of Health by Viva Med Hospital on December 18, 2020 for toxological analysis, and the same was found to have no toxins.

8.54 I now turn to the Fourth and Fifth Defendants, the registered nurses. The two on the material date respectively assisted the Second and Third Defendants. While it is true that Linnah Chibwe, the Fifth Defendant was not an intensive care nurse, but a general nurse, she operated under the instruction and supervision of the Third Defendant, who is a critical care specialist/ intensivist.

8.55 There is nothing to suggest that the Fifth Defendant did her work below the expected reasonable standard of a health practitioner in her position. The allegation of her being negligent and somehow having caused the death of the deceased is transcendently remote. In fact, the General Nursing Council confirmed that, despite Linnah Chibwe not being a critical care nurse, she was able to work under the supervision of a critical specialist, in respect of the procedure that was undertaken.

8.56 Similarly, the Fourth Defendant was a registered nurse working under the supervision of the Second and Third Defendants. The issue is whether the accuracy of the preoperative checklist prepared by her met the necessary standard of care in the

circumstances. This contention revolved around shading the information initially recorded in the preoperative form on the known allergies section as opposed to striking out the said information, when correcting the fact that the patient had an allergy to Tramadol, which the patient initially did not disclose.

8.57 It was submitted that the Fourth Defendant acknowledged that the proper practice in this regard was to strike out the information being changed /corrected but that this was not done due to human error. It was contended that the inconsequentiality and insignificance of this error was corroborated by PW2 when he confirmed in cross examination that the form properly fulfilled its purpose in terms of identifying the allergies of the patient.

8.58 I agree that despite human error in the manner the Fourth Defendant erased the part that stated that the deceased had no allergies, in the face of clear admittance that the same was done due to human error, I don't see how this minor act affected the rest of the procedure conducted on the deceased. Moreover, it did not affect the information stated on the consent form, neither did it cause the death of the deceased.

8.59 I now turn to the alleged liability of Viva Med Hospital. As earlier noted, the Hospital owed the deceased a duty of care to ensure, that its health practitioners, practicing under its management subject to the class of its facility and the requisite equipment, had the required skills set and discharged their duties with the required duty of care. Having found the Second Defendant to the Fifth Defendants professionally flawless, the allegations of

negligence on the part of the first Defendant on account of its health practitioners is untenable.

8.60Lastly, I turn to the alleged breach of statutory duty on the part of the Sixth Defendant, HPCZ. By way of recall, it was alleged that the HPCZ breached its statutory duty by granting Viva Med Hospital a Class A licence without an ICU facility. However, HPCZ rejoined that even though Viva Med Hospital did not have an ICU, it had a High Dependency Unit (HDU) with all equipment, and thus qualified for a Class A Licence at Level 1.

8.61 I do not hesitate to agree with HPCZ that Viva Med Hospital had all the requisite facilities to qualify for a Class A Licence, and operate as such, and was competent to admit the deceased as an in-patient on December 18, 2020 for surgery, in particular lumpectomy. The HDU which was in place at the material time was medically and by statute sufficient.

8.62 Likewise, the transfer of the deceased from Viva Med Hospital to CFB as a horizontal transfer was not unusual or uncommon practice, and did not by any sense suggest that Viva Med Hospital was irregularly classified, to warrant its disqualification or to be stripped of its deserving status as a Class A Health Facility accredited at Level 1.

8.63 And regarding arguments by the Plaintiff that there was need for Viva Med Hospital to have a CT scan, the evidence shows that the same was not a mandatory requirement, neither was it listed as a mandatory tool or equipment that a Class A health facility, the type that Viva Med Hospital which is Class A level 1, should

have. And as stated by DW10, Class A Level 1 health facilities were entry facilities in that class.

8.64 I find that there was no breach of statutory duty on the part of the HPCZ in the manner it discharged its duties to accredit Viva Med Hospital as a Class A Health Facility. Similarly, the regular monitoring of Viva Med Hospital by HPCZ up to the time Viva Med Hospital carried out lumpectomy on the deceased was devoid of statutory blame. And I should add that the investigations so far carried out by HPCZ against Viva Med Hospital and the subject health practitioners is hitherto incensurable.

9.0 CONCLUSION

9.1 In the light of the foregoing, the Plaintiff's claims fail in their entirety. The First to the Fifth Defendants did not whatsoever negligently cause the death of Mrs Agnes Kaluzi Mdala on December 18, 2020, but professionally discharged their duties in accordance within the required standard of their practice. Likewise, the HPCZ did not cause the death of Mrs. Mdala. The Class A Health Facility Licence was duly issued to Viva Med Hospital, and the monitoring and inspection of Viva Med Hospital by HCPZ was flawless. Therefore, the untimely death Mrs Mdala was remote to the perceived actions or omissions of the HPCZ.

9.2 The Plaintiff's claims having failed, generally, the Plaintiff should have been condemned to pay the Defendants' costs. However, I order that each party bears their own costs, in the

light of the fact that the case brought out novel legal issues, particularly the duty to warn connected to causation espoused in the ***Chester*** case, and public interest issues regarding the statutory role of HPCZ in regulating health facilities in so far as safeguarding the lives of people seeking medical services is concerned.

9.3 Leave to appeal is granted.

DATED THE 10TH DAY OF DECEMBER 2024

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THE HON. MR. JUSTICE CHARLES ZULU