(2023)

SCZ Judgment No. 52/2014

IN THE SUPREME COURT OF ZAMBIA APPEAL NO.68/2010
HOLDEN AT LUSAKA
(CIVIL JURISDICTION)

BETWEEN:

THE ATTORNEY-GENERAL APPELLANT

AND

ROSEMARY MULENGA RESPONDENT

Coram: Chibesakunda, Ag. CJ, Wood and Kaoma, JJS.

On the 12th of August, 2014 and 21st November, 2014

For the Appellant: Mrs. S.M. Wajelani - Principal State Advocate
For the Respondent: Mr. M.P. Muyawala- Dzekedzeke and Company

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JUDGMENT

Kaoma, JS, delivered the Judgment of the Court.

Cases Referred to:

1. *Cicuto Davidson v Oliver (1968) Z.R. 149*
2. *Edna Nyasulu v Attorney-General (1993) Z.R. 105*
3. *Ndola Central Board of Management v Kaluba & anr (1995-97) Z.R. 215*
4. *Bolam v Friern Hospital Management Committee (1957) 2All ER 116*
5. *Rosemary Bwalya v ZCCM Limited & ors (2005) Z.R. 1*
6. *Kanhaiya Research Centre (1999) CPJ 9 (NC)*

7. Hatcher v Black CPS 1992 (11) 764
8. Roe v Ministry of Health (1954) 2 ALL ER, 131 at 139

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10. Lupapa v The People (1977) Z.R. 38
11. Chuba v The People (1976) Z.R. 272
12. Hambridge v Harrison (1975) 1 Lloyds
13. Duff Kopa Kopa (suing as next friend and administrator of the estate of Chuubo Kopa Kopa) v University Teaching Hospital Board of Management – SCZ Judgment No. 8 of 2007

Other works referred to:

1. Winfield and Jolowicz on Tort

This is an appeal against the decision of the High Court at Lusaka by which the respondent was awarded general damages for negligence, special damages, interest and costs. The respondent had claimed against the appellant the sum of K45 million as special and general damages arising from pain and suffering as a result of the injection which was negligently administered and embedded in her left upper thigh from 9th August to 3rd November, 2004.

The facts of the matter which were not in dispute are that the respondent, who was aged 50 years, was taken suddenly ill with chest problems, sneezing and headache. She sought treatment at George Clinic, a government clinic, in George Compound in Lusaka. Amongst the medicines prescribed by the

doctor were five injections of procaine penicillin 2cc each. The respondent had the five

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injections from 6th or 7th August, 2004. The first two injections were administered by one nurse and the last three by a different nurse.

The respondent had no problem with the first two and last two injections. But she had a problem with the third injection she received on 9th August. That day she smelt the drug; bled on the injection site and was in pain. She also had heart palpitations and spent a sleepless night. The next day she informed the attending nurse who advised her to massage and place ice blocks on the injection site which she did, but the pain became excruciating as days passed causing her to consult a doctor at the same clinic.

After examining the injection site, the doctor prescribed pain killers which did not help. The respondent asked to be referred to UTH, but the request was turned down. The doctor thought it was unnecessary. She then decided to consult Dr. Lambart at a private clinic who suggested that an x-ray be taken. She went to

UTH and was seen by a doctor who also ordered an x-ray. The x-ray showed a hypodermic needle in the respondent's right gluteal region.

On 3rd November, 2014 the respondent was admitted at UTH pending an operation. She was operated on by Dr. Mbambiko, a

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surgical registrar who confirmed removing a hypodermic needle from the respondent's perineum, which is the area between the genital area and the anus.

Simon Mwaba Mulenga (PW2), the respondent's husband confirmed that the respondent sustained a swollen leg after the third injection, she had sleeping problems and high blood pressure and that she went back to the clinic, but she never improved.

Dr. Mbambiko (PW3) testified for the respondent that it was possible for the foreign body to be found where it was since the needle broke in the muscle in the buttock and must have moved when sitting or moving, as foreign bodies migrate; and the respondent would be in pain as the needle moved. He opined that the migration was due to physical pressure, and massaging the

area as the respondent was advised at the clinic may have contributed to the migration of the needle. In cross examination he said there was infection in the buttock after the injection. He also said he operated on her in a sensitive area which may affect her sexual life, and that asthma is an allergic reaction.

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Dr. James Munthali (DW1) a lecturer and human anatomy orthopedic and trauma surgeon testified for the appellant as an expert witness. In his words, it was very difficult to figure out how the foreign body could have migrated from the injection site to where it ended up because such a migration would appear to defy all the known principles by which foreign bodies move. He opined that the only way the needle could have ended up where it was found was if it broke off directly in that region. However, he said the case presented phenomena which could not be explained. He agreed with Dr. Mbambiko’s report, but said the cases the latter cited though correct; do not throw light on how the needle migrated.

Manje Lungu Lushito (DW2), the attending nurse could not recall administering the problematic injection since they inject close to a 100 people per day and the respondent did not complain to her. She said she did not notice anything abnormal and that it was possible that the source of the needle was their clinic or elsewhere.

Agness Mbewe Sitanzye (DW3), the sister-in-charge at the clinic received a report of the incident from PW2 after the needle

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had been removed. She confirmed that the respondent had received five injections from 7th to 11th August, 2004 and she saw the needle that was removed from the respondent. She thought the needle looked bigger than the needles in use at the clinic.

After reviewing the evidence and some authorities relating to *res ipsa loquitur*, including the cases of *Cicuto v Davidson and Oliver*[1], *Edna Nyasulu v The Attorney General*[2] (both High Court decisions) and *Ndola Central Board of Management v Kaluba and another*[3], the learned judge entered judgment for the respondent and directed that the damages be assessed by the Deputy Registrar.

Aggrieved by the judgment, the appellant has appealed on three grounds. The first ground is that the learned judge below erred in law and fact when he held that negligence was established against the appellant by the fact that a needle was removed from the respondent's body. The second ground is that the learned judge erred in law and fact when he did not take into consideration the evidence of DW3 which stated that the needle did not originate from the appellant's clinic. The third ground is that the learned judge

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erred in law and fact when he attached weight to the evidence of PW3 and completely ignored the evidence of DW1.

In support of grounds 1 and 2, the learned Principal State Advocate cited the well known principles on negligence espoused by *Winfield and Jolowicz on Tort*. She also cited the case of *Bolam v Friern Hospital Management Committee*[4] approved by this Court in *Rosemary Bwalya v ZCCM Limited and others*[5]. She further quoted the Indian case of *Kanhaiya Research Centre*[6] and argued that the trial judge was wrong to hold that there was negligence

on the part of the appellant without establishing that the needle found in the respondent was in fact left by the appellant.

She argued that the mere finding that since the respondent was attended to at the appellant's clinic, then it follows that the hypodermic needle removed from her body originated from the clinic, is not supported by any evidence. That according to DW2 the source of the needle could have been the clinic or elsewhere, and DW3's unchallenged evidence was that the needle which was removed from the respondent did not come from the clinic as it was bigger than the normal needles in use at the clinic.

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The learned Principal State Advocate also cited the cases of *Cicuto v Davidson and Oliver*[1], *Edna Nyasulu v Attorney-General*[2], *Hatcher v Black CPS*[7], and *Roe v Ministry of Health*[8] and argued that the facts and circumstances of this case do not establish a prima facie case of negligence against the appellant; and that the fact that a needle was removed from the respondent's body is not sufficient nor conclusive proof that the needle came from the appellant.

It was further argued that the mere fact that the respondent bled and felt some pain on the injection site after the third injection does not imply negligence on the part of the appellant or the nurse who administered the injection. That the learned judge failed to take judicial notice of the fact that pain and bleeding from the site of an injection are common occurrence and that this could not be the basis upon which the employee should be considered as having been negligent in administering the injection.

She concluded that the evidence on which the learned judge relied and the doctrine of *res ipsa loquitur* do not warrant the finding of negligence on the part of the appellant.

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As regards ground 3, the learned Principal State Advocate cited the cases of *Lupapa v The People*[9] and *Chuba v The People*[10] for the principle that expert evidence is there to provide the court with the necessary scientific criteria for testing the accuracy of facts before it so as to enable the court form its own independent judgment. She argued that the respondent called PW3 while the

appellant called DW1 as expert witnesses and that the latter was more specialized in the field under consideration than the former.

She submitted that DW1 said it was impossible for the needle to move in the way it is alleged to have moved and more importantly he explained, and this was not challenged, that the most obvious way the needle could have ended up where it was found was if it broke off directly in that region, but the judge, for reasons he did not state, decided to ignore that in favour of the testimony of PW3.

Counsel further cited *Hambridge v Harrison*[11] where she argued two experts were called to give their opinion and there was an insufficient degree of congruence for the Court of Appeal to treat the reports as agreed and it was said that the court may require that experts hold discussions within the subject of identifying the

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true scope of dispute between them and for the purpose of narrowing disputes between them.

She argued that since the evidence of two experts conflicted, the court should have taken deliberate steps to ensure

that there was a sufficient degree of congruence before weighing the credibility of either of the witnesses, and ought to have appointed a single joint expert. She urged that there is a higher degree of probability required to prove negligence in professional cases and that the respondent failed to establish that.

In reply to grounds 1 and 2, counsel for the respondent submitted that on the question of whether or not negligence was established, the facts prove that the respondent upon experiencing the discomfort reported the pain to the attending nurse.

That even after the complaint was repeated the nurse insisted that a massage and ice blocks be applied instead of advising the respondent for a second opinion, to which the doctor at long last responded negatively. That if a second opinion had been sought early enough, the respondent was not going to suffer to the extent that she did; and both the nurse and the doctor who decided that it

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was not necessary to go to UTH displayed a degree of negligence that cannot fit squarely into the authorities cited by the appellant.

Counsel for the respondent acknowledged the decision in the *Kanhaiya Research Center*[6] case to the effect that negligence must be established and not presumed, but submitted that in the case at the bar, the respondent wanted to seek a second opinion but it was said that it was not necessary. According to counsel, though it can be argued that there is no case to answer unless the respondent produces reasonable evidence that whatever happened was caused by negligence of the appellant, there is no other type of evidence that can be produced than that given in the facts of this case.

With regard to the third ground of appeal, counsel submitted that after DW1 gave an academic explanation of how foreign bodies can migrate in a human body, he summarised his evidence by stating that medical science is dynamic and he agreed with the opinion of PW3. He urged us to dismiss the appeal with cost.

We have considered with a lot of care the judgment appealed against and the arguments of counsel and the authorities cited. We have no doubt that this is a case of medical malpractice

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based upon a claim that the appellant's servants as health care providers were negligent. It is trite that to establish negligence, the plaintiff must prove that the practitioner's actions fell below the accepted standard of care, or the degree of care a reasonable, similarly qualified health care provider would have provided under the same or similar circumstances (*Bolam v Friern Hospital Management Committee*[4], *Rosemary Bwalya v ZCCM Ltd & others*[5]).

It is also trite that a hospital, doctor or other health care professional is not liable for all the harm a patient might suffer. They are only legally liable for harm or injury that results from their deviating from the quality of care that a competent doctor or health care provider would normally provide in similar situations. The injury may be physical, emotional or pecuniary, such as constant pain, hardship, loss of income, and injury that disabled the patient.

In *Rosemary Bwalya v ZCCM Limited and others*[5], *Duff Kopa Kopa (suing as next friend and administrator of the estate of Chuubo Kopa Kopa) v University Teaching Hospital Board of Management*[12] we said in determining whether a defendant

practitioner has fallen below the required standard of care, the law looks to responsible

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medical opinion, and a practitioner who acts in conformity with an accepted, approved and current practice is not negligent.

In the present case, it is very clear from the evidence that the respondent accused the attending nurse (DW2) of negligence in breaking off the hypodermic needle in her body and the attending doctor of negligence in a failure to immediately send her to seek for a second opinion after she complained of continuous pain.

At the trial the respondent led evidence that was not challenged. As we have already said, she went to the clinic after she experienced chest problems, sneezing and headache. The doctor prescribed five injections of procaine penicillin. She was given the injections by two nurses employed at the clinic, one of them DW2. She had no problems with four of the injections. But the third injection administered by DW2 on 9th August, 2004 gave her problems. She smelt the drug and she bled. She was in pain as she went home and had heart palpitations. She took bed rest,

but the pain continued. The next day she told DW2 that she had a sleepless night due to pain. DW2 advised her to massage the area with ice blocks, but the pain persisted.

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On 19th August, 2004 she saw the doctor who gave her a prescription. However, the pain and heart palpitations continued and became severe. She could only eat light food like porridge. She told the doctor that the pain was severe and the left leg was getting swollen and asked for a referral to UTH, but the doctor said it was not necessary. Instead, he gave her another prescription. She took the medicines but the problem continued.

It was Dr. Lambart who requested for an x-ray which when taken showed a hypodermic needle in the gluteal region. When she was operated on, the hypodermic needle was removed from the perineum and given to her. The needle was produced as exhibit P1 at the trial. The respondent testified that while the wound healed, the chest felt blocked as if she was asthmatic. At the time of trial she continued to have heart palpitations and chest problems and the left leg still gave her problems and the toes had a numb feeling.

PW2 confirmed that the respondent endured pain after the third injection. He added that on the fourth day she could not even move, so he drove her to the clinic, the leg was swollen; she had sleeping problems and high blood pressure. She kept going to the

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clinic, but never improved. Before that she was not a high blood pressure patient or asthmatic.

We are satisfied that there was adequate evidence on the issues involved for the learned judge to make a finding of negligence against the appellant. First of all, as can be seen from the respondent's uncontradicted evidence she started experiencing all the problems alluded to above after the third injection that bled. In fact in cross-examination she said the spot injected felt as if there was something solid. The pain persisted until the x-ray revealed that she had a hypodermic needle in the perineum.

Secondly, we have no doubt that the appellant's servants owed to the respondent a duty to use reasonable care and skill in administering the injections to her and in treating her. Thirdly, the

learned judge's finding of negligence was not based solely on the fact that a needle was removed from the respondent's body or on the fact she smelt the drug and bled and felt pain.

We accept that a patient would normally bleed and feel pain when an injection is administered. But in this case the circumstantial evidence was enough to warrant a finding that the

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needle was inserted and broken off in the respondent's buttock when DW2 administered the third injection.

In *Rosemary Bwalya v ZCCM Limited and others*[5] *and Duff Kopa Kopa (suing as next friend and administrator of the estate of Chuubo Kopa Kopa) v University Teaching Hospital Board of Management*[13], we said a medical practitioner who acts in conformity with an accepted, approved and current practice is not guilty of negligence, merely because there is a body of opinion who would take a contrary view. However, those cases are distinguishable on the facts from the case at the bar.

In this case, the breaking of a hypodermic needle in the respondent's body by the appellant's servant while administering an injection is prima facie negligence. In fact the respondent

complained to DW2 the next day about the pain and was advised to massage the area with ice blocks. In addition, even if DW2 said she did not notice anything abnormal, we find that she was negligent in failing to discover after administering the injection, that the needle had broken into the muscle in the buttock, and in failing to remove it or advise the respondent thereof.

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The appellant argues that there was no evidence by the respondent of the breaking of the needle in her buttock. As rightly put by the learned judge, a plaintiff can only prove factually that which can be proved. It is not often that negligence of this type can be proved by direct evidence. The doctrine of *res ipsa loquitur,* which the learned judge applied, allows a plaintiff to use circumstantial evidence to infer negligence.

In other words, the elements of duty of care and breach can be inferred from the very nature of an accident or other outcome, even with no direct evidence of how the defendant behaved. And once the plaintiff satisfies the preconditions of *res ipsa loquitur*, the court will presume that the health care provider was negligent

and the burden of proof shifts to the health care provider to prove otherwise.

Of course, 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

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medicine, with all its attendant costs in professional attention and resources (See *Roe v Ministry of Health*[8]).

But this case is based upon circumstantial evidence, from which a reasonable inference of negligence could be drawn, and whether this inference should be drawn and which of the parties' evidence should be believed, was a question for the judge to decide. In the end the judge decided to believe the respondent's evidence. We have no difficulty, whatsoever, in accepting, as the learned judge did, that the nurse and the doctor at George clinic failed to provide the proper standard of care in treating the

respondent and that the failure resulted in considerable injury to the respondent.

Even as we appreciate that it is for the doctor or health care provider to exercise his skill and judgment in deciding on the treatment of a patient, and that it is not the doctor's duty simply to accede to the request of a patient, it is still for the doctor to decide whether the request is in the patient's best interest. In the *Duff Kopa Kopa*[12] case we said in all cases general practitioners and other doctors must exercise care in determining when to refer a patient for a consultant's or other second opinion.

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In this case there was no evidence by the attending doctor at George clinic to shed light on why he did not refer the respondent to UTH following the prolonged and excruciating pain. Therefore, we are unable to say that the doctor acted reasonably and in conformity with an accepted, approved and current practice. The learned judge properly distinguished the cases of *Cicuto v Davidson and Oliver*[1], and *Edna Nyasulu v The Attorney-General*[2] and properly applied the case of *Ndola Central Board of Management v Kaluba and another*[2] where we held that the

doctrine of *res ipsa loquitur* did not have to be specifically pleaded. We find no merit in ground 1.

Regarding ground 2, it has been argued for the appellant that there was no conclusive proof that the needle which was removed from the respondent’s body originated from the clinic; and that the mere fact that the respondent was attended to at the clinic, did not mean the needle came from there.

Undoubtedly, there was no evidence before the trial judge to suggest or show that the respondent had been treated or injected elsewhere before the doctor at George clinic prescribed the five

injections and no questions to that effect were put to the respondent or to her witnesses in cross-examination.

We were referred to the evidence of DW2 at page 137 of the record of appeal. As rightly observed by the learned judge, DW2 had no recollection of giving the problematic injection. However, she saw the needle in the x-ray picture. Her testimony is that it may be possible that the source was their clinic or elsewhere.

And contrary to the argument by the appellant that DW3's testimony is that the needle which was removed from the respondent did not come from their clinic because it was bigger than the normal hypodermic needles in use at the clinic, the evidence of DW3 at page 140 of the record shows that the witness thought the needle looked bigger than the needles they use at the clinic. She did not conclusively say that the needle did not come from the clinic.

Besides, there was no evidence that the needle removed from the respondent's body was compared with the needles in use at the clinic at the time to confirm DW3's thinking that the needle in question was bigger than those at the clinic. In our view, the

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learned judge was on firm ground when he dismissed the suggestion that the needle did not originate from the appellant's clinic. As a result, ground 2 too has no merit.

We turn now to ground 3 alleging that the learned judge attached weight to the evidence of PW3 and ignored that of DW1. It is clear to us that the learned judge based his conclusion on the

evidence of both doctors. The learned judge said as follows at pages 17 and 18 of the record of appeal:

> ***"And, as for medical opinions; Dr. Munthali said it was difficult to account for the movement of the hypodermic needle from the injection site to where it was removed but did say, under cross examination, that in medicine, one does not generally say, 'this cannot happen,' because exceptional occurrences do happen in medicine whereas Dr. Mbambiko's opinion, as contained in his quoted report, is that medical knowledge on the movement of foreign bodies in patients is at times difficult to understand.***
>
> ***It follows, therefore, that it cannot be suggested that the needle did not move from the injection site to where it was found just because it is difficult to explain. The facts speak for themselves."***

It was argued that from the qualifications of the two doctors, DW1 was more specialized in the field under consideration than PW3. We note that whilst PW3, who removed the needle from the respondent testified that the needle broke in the muscle in the

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buttock, DW1 did not address the issue of whether the standard of care was breached by DW2 or the doctor who decided that it was not necessary to refer the patient to UTH. He simply tried to convince the court that the needle could not have moved from the injection site to the perineum.

In a medical negligence case, the testimony of a competent expert witness is generally necessary in order for the plaintiff to show a breach of the standard of care and also often to satisfy the causation element in such claims. As we have said the law looks to responsible medical opinion. But with *res ipsa loquitur* the plaintiff does not have to specify in what respects the defendant's conduct was negligent. However, expert testimony could still support the conclusion that the type of injury suffered was more likely than not the result of negligent conduct by the defendant.

In this case, DW1 testified that it was impossible for the needle to move in the way it is alleged to have moved either through blood as the area has its own source of blood supply or if it followed muscles, it may have ended up in the hip. In his words, the most obvious way the needle could have ended up where it was found

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was if it broke off directly in that region. We are not sure whether the doctor was suggesting that the respondent was injected directly in the perineum. If so, such proposition, absurd as it

sounds, was never put to the respondent or to PW3 in cross examination.

What is more, DW1 testified that movement of muscles and tissues can propel a sharp pointed foreign body; and massaging the area, as the patient was advised could have assisted the needle to go further away from the point where it was introduced. He conceded that medicine is dynamic; that they occasionally find new areas surfacing; and that some phenomena are difficult to explain and you do not say in medicine ‘never’. He also admitted that PW3’s statement in his report was a fair statement.

Clearly, the learned judge believed, after analysing the expert evidence from both doctors, that in the 85 days period after the third injection was administered, the needle had moved from the injection site to the area where it was removed from. We are satisfied that the facts presented by the evidence, and the very nature of the occurrence, shows a prima facie case of negligence in failing to exercise due care in nursing and treatment of the patient.

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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 cases may too often depend on the expert's success in promoting their clients' side, rather than in objectively educating the trier of fact and facilitating a just resolution of the matter.

This is why we have time and again said the opinion of an expert can only be a guide, though a strong guide, to the court in arriving at its own conclusion on the evidence before it. In this case the learned judge arrived at the right conclusion and there was no need for the court to appoint a single joint expert witness. In our view ground 3 too has no merit.

All in all we find no merit in the whole appeal and we dismiss it with costs to be taxed if not agreed.

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L. P. CHIBESAKUNDA
ACTING CHIEF JUSTICE

A. M. WOOD
SUPREME COURT JUDGE

R. M. C. KAOMA
SUPREME COURT JUDGE