Republic of the Philippines
Supreme Court
Manila

SECOND DIVISION

NOEL CASUMPANG, RUBY SANGA-MIRANDA and SAN JUAN DE DIOS HOSPITAL,
Petitioners,

- versus -

NELSON CORTEJO,
Respondent.
x----------x

DRA. RUBY SANGA-MIRANDA,
Petitioner,

- versus -

NELSON CORTEJO,
Respondent.
x----------x

SAN JUAN DE DIOS HOSPITAL,
Petitioner,

- versus -

NELSON CORTEJO,
Respondent.
x----------x

G.R. No. 171127

G.R. No. 171217

G.R. No. 171228

Present:

CARPIO, *J., Chairperson,*
BRION,
VILLARAMA, JR.,*
MENDOZA, and
LEONEN, *JJ.*

Promulgated:

11 MAR 2015

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* Designated as additional member in lieu of Associate Justice Mariano C. Del Castillo per raffle dated February 9, 2015.

D E C I S I O N

BRION, *J.*:

We resolve the three (3) consolidated petitions for review on *certiorari*[1] involving medical negligence, commonly assailing the October 29, 2004 decision[2] and the January 12, 2006 resolution[3] of the Court of Appeals (*CA*) in CA-G.R. CV No. 56400. This CA decision affirmed *en toto* the ruling of the Regional Trial Court (*RTC*), Branch 134, Makati City.

The RTC awarded Nelson Cortejo (*respondent*) damages in the total amount of ₱595,000.00, for the wrongful death of his son allegedly due to the medical negligence of the petitioning doctors and the hospital.

Factual Antecedents

The common factual antecedents are briefly summarized below.

On April 22, 1988, at about 11:30 in the morning, Mrs. Jesusa Cortejo brought her 11-year old son, Edmer Cortejo (*Edmer*), to the Emergency Room of the San Juan de Dios Hospital (*SJDH*) because of difficulty in breathing, chest pain, stomach pain, and fever.[4]

Dr. Ramoncito Livelo (*Dr. Livelo*) initially attended to and examined Edmer. In her testimony, Mrs. Cortejo narrated that in the morning of April 20, 1988, Edmer had developed a slight fever that lasted for one day; a few hours upon discovery, she brought Edmer to their family doctor; and two hours after administering medications, Edmer's fever had subsided.[5]

After taking Edmer's medical history, Dr. Livelo took his vital signs, body temperature, and blood pressure.[6] Based on these initial examinations and the chest x-ray test that followed, Dr. Livelo diagnosed Edmer with "*bronchopneumonia*.[7]" Edmer's blood was also taken for testing, typing, and for purposes of administering antibiotics. Afterwards, Dr. Livelo gave Edmer an antibiotic medication to lessen his fever and to loosen his phlegm.

Mrs. Cortejo did not know any doctor at SJDH. She used her Fortune Care card and was referred to an accredited Fortune Care coordinator, who

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1 Under Rule 45 of the Rules of Court.

2 *Rollo*, (G.R. No. 171127) pp. 19-32, penned by Associate Justice Vicente Q. Roxas, and concurred in by Associate Justice Salvador J. Valdez, Jr. and Associate Justice Juan Q. Enriquez, Jr.

3 Id. at 34-38.

4 TSN, Jesusa Cortejo, November 27, 1990, pp. 2-3; TSN, Ramoncito Livelo, February 16, 1993, pp. 5-6. (per *rollo*, G.R. No. 171228, pp. 106-107)

5 TSN, May 2, 1991, pp. 12-16.

6 TSN, Dr. Ramoncito Livelo, February 16, 1993, pp. 5-6.

7 Id.

was then out of town. She was thereafter assigned to Dr. Noel Casumpang (*Dr. Casumpang*), a pediatrician also accredited with Fortune Care.[8]

At 5:30 in the afternoon of the same day, Dr. Casumpang for the first time examined Edmer in his room. Using only a stethoscope, he confirmed the initial diagnosis of "*Bronchopneumonia.*"[9]

At that moment, Mrs. Cortejo recalled entertaining doubts on the doctor's diagnosis. She immediately advised Dr. Casumpang that Edmer had a high fever, and had no colds or cough[10] but Dr. Casumpang merely told her that her son's "*blood pressure is just being active,*"[11] and remarked that "*that's the usual bronchopneumonia, no colds, no phlegm.*"[12]

Dr. Casumpang next visited and examined Edmer at 9:00 in the morning the following day.[13] Still suspicious about his son's illness, Mrs. Cortejo again called Dr. Casumpang's attention and stated that Edmer had a fever, throat irritation, as well as chest and stomach pain. Mrs. Cortejo also alerted Dr. Casumpang about the traces of blood in Edmer's sputum. Despite these pieces of information, however, Dr. Casumpang simply nodded, inquired if Edmer has an asthma, and reassured Mrs. Cortejo that Edmer's illness is bronchopneumonia.[14]

At around 11:30 in the morning of April 23, 1988, Edmer vomited "phlegm with blood streak"[15] prompting the respondent (*Edmer's father*) to request for a doctor at the nurses' station.[16]

Forty-five minutes later, Dr. Ruby Miranda-Sanga (*Dr. Sanga*), one of the resident physicians of SJDH, arrived. She claimed that although aware that Edmer had vomited "phlegm with blood streak," she failed to examine the blood specimen because the respondent washed it away. She then advised the respondent to preserve the specimen for examination.

Thereafter, Dr. Sanga conducted a physical check-up covering Edmer's head, eyes, nose, throat, lungs, skin and abdomen; and found that Edmer had a low-grade non-continuing fever, and rashes that were not typical of dengue fever.[17] Her medical findings state:

> the patient's rapid breathing and then the lung showed sibilant and the patient's nose is flaring which is a sign that the patient is in respiratory distress; the abdomen has negative finding; the patient has low grade fever

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8 TSN, Jesusa Cortejo, November 27, 1990, pp. 5-7.
9 Id. at 7.
10 Id. at 4-5.
11 Id. at 14.
12 Id. at 8.
13 Id.
14 Id. at 5-7.
15 More of coffee ground material.
16 TSN, Nelson Cortejo, July 16, 1991, pp. 6-8. Nelson Cortejo testified that his son vomited a brown liquid and particles that look like dead blood.
17 Id. at 10.

> and not continuing; and the rashes in the patient's skin were not "Herman's Rash" and not typical of dengue fever.[18]

At 3:00 in the afternoon, Edmer once again vomited blood. Upon seeing Dr. Sanga, the respondent showed her Edmer's blood specimen, and reported that Edmer had complained of severe stomach pain and difficulty in moving his right leg.[19]

Dr. Sanga then examined Edmer's "*sputum with blood*" and noted that he was bleeding. Suspecting that he could be afflicted with dengue, she inserted a plastic tube in his nose, drained the liquid from his stomach with ice cold normal saline solution, and gave an instruction not to pull out the tube, or give the patient any oral medication.

Dr. Sanga thereafter conducted a tourniquet test, which turned out to be negative.[20] She likewise ordered the monitoring of the patient's blood pressure and some blood tests. Edmer's blood pressure was later found to be normal.[21]

At 4:40 in the afternoon, Dr. Sanga called up Dr. Casumpang at his clinic and told him about Edmer's condition.[22] Upon being informed, Dr. Casumpang ordered several procedures done including: *hematocrit, hemoglobin, blood typing, blood transfusion and tourniquet tests*.

The blood test results came at about 6:00 in the evening.

Dr. Sanga advised Edmer's parents that the blood test results showed that Edmer was suffering from "Dengue Hemorrhagic Fever." One hour later, Dr. Casumpang arrived at Edmer's room and he recommended his transfer to the Intensive Care Unit (*ICU*), to which the respondent consented. Since the ICU was then full, Dr. Casumpang suggested to the respondent that they hire a private nurse. The respondent, however, insisted on transferring his son to Makati Medical Center.

After the respondent had signed the waiver, Dr. Casumpang, for the last time, checked Edmer's condition, found that his blood pressure was stable, and noted that he was "comfortable." The respondent requested for an ambulance but he was informed that the driver was nowhere to be found. This prompted him to hire a private ambulance that cost him ₱600.00.[23]

At 12:00 midnight, Edmer, accompanied by his parents and by Dr. Casumpang, was transferred to Makati Medical Center.

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18 TSN, Ruby Sanga-Miranda, June 8, 1988, pp. 13-19.
19 TSN, Nelson Cortejo, July 16, 1991, p. 12.
20 Id. at 11-13.
21 Id.
22 TSN, Ruby Miranda-Sanga, June 10, 1993, pp. 35-36.
23 TSN, Nelson Cortejo, July 16, 1991, p. 20.

Dr. Casumpang immediately gave the attending physician the patient's clinical history and laboratory exam results. Upon examination, the attending physician diagnosed "Dengue Fever Stage IV" that was already in its irreversible stage.

Edmer died at 4:00 in the morning of April 24, 1988.[24] His Death Certificate indicated the cause of death as "Hypovolemic Shock/hemorrhagic shock;" "Dengue Hemorrhagic Fever Stage IV."

Believing that Edmer's death was caused by the negligent and erroneous diagnosis of his doctors, the respondent instituted an action for damages against SJDH, and its attending physicians: Dr. Casumpang and Dr. Sanga (*collectively referred to as the "petitioners"*) before the RTC of Makati City.

The Ruling of the Regional Trial Court

In a decision[25] dated May 30, 1997, the RTC ruled in favor of the respondent, and awarded actual and moral damages, plus attorney's fees and costs.

In ruling that the petitioning doctors were negligent, the RTC found untenable the petitioning doctors' contention that Edmer's initial symptoms did not indicate dengue fever. It faulted them for heavily relying on the chest x-ray result and for not considering the other manifestations that Edmer's parents had relayed. It held that in diagnosing and treating an illness, the physician's conduct should be judged not only by what he/she saw and knew, but also by what he/she could have reasonably seen and known. It also observed that based on Edmer's signs and symptoms, his medical history and physical examination, and also *the information that the petitioning doctors gathered from his family members*, dengue fever was a reasonably foreseeable illness; yet, the petitioning doctors failed to take a second look, much less, consider these indicators of dengue.

The trial court also found that aside from their self-serving testimonies, the petitioning doctors did not present other evidence to prove that they exercised the proper medical attention in diagnosing and treating the patient, leading it to conclude that they were guilty of negligence.

The RTC also held SJDH solidarily liable with the petitioning doctors for damages based on the following findings of facts: *first*, Dr. Casumpang, as consultant, is an **ostensible agent of SJDH** because before the hospital engaged his medical services, it scrutinized and determined his fitness, qualifications, and competence as a medical practitioner; and *second*, Dr. Sanga, as resident physician, is an **employee of SJDH** because like Dr. Casumpang, the hospital, through its screening committee, scrutinized and

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24 RTC Records, p. 211.
25 CA *rollo*, pp. 535-551.

determined her qualifications, fitness, and competence before engaging her services; the hospital also exercised control over her work.

The dispositive portion of the decision reads:

> WHEREFORE, judgment is hereby rendered in favor of the plaintiff and against the defendants, ordering the latter to pay solidarily and severally plaintiff the following:
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> (1) Moral damages in the amount of ₱500,000.00;
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> (2) Costs of burial and funeral in the amount of ₱45,000.00;
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> (3) Attorney's fees of ₱50,000.00; and
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> (4) Cost of this suit.
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> SO ORDERED.

The petitioners appealed the decision to the CA.

The Ruling of the Court of Appeals

In its decision dated October 29, 2004, the CA affirmed *en toto* the RTC's ruling, finding that SJDH and its attending physicians failed to exercise the minimum medical care, attention, and treatment expected of an ordinary doctor under like circumstances.

The CA found the petitioning doctors' failure to read even the most basic signs of "*dengue fever*" expected of an ordinary doctor as medical negligence. The CA also considered the petitioning doctors' testimonies as self-serving, noting that they presented no other evidence to prove that they exercised due diligence in diagnosing Edmer's illness.

The CA likewise found Dr. Rodolfo Jaudian's (*Dr. Jaudian*) testimony admissible. It gave credence to his opinion[26] that: *(1) given the exhibited symptoms of the patient, dengue fever should definitely be considered, and bronchopneumonia could be reasonably ruled out; and (2) dengue fever could have been detected earlier than 7:30 in the evening of April 23, 1988 because the symptoms were already evident;* and agreed with

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[26] *"[If] the patient is admitted for chest pain, abdominal pain, and difficulty of breathing, dengue fever will definitely be considered;" "if the patient expectorated coffee ground, and with the presence of bleeding, it is a clear case of dengue fever, broncho pneumonia could be reasonably ruled out;" "if the patient complained of rapid breathing, chest and stomach pain, the management should be oxygen inhalation, analgesic, and infuse liquids or dextrose;" "if the patient had expectorated fresh blood twice already and thrombocytopenia has occurred, management should be blood transfusion, monitoring every 30 minutes, give hemostatic to stop bleeding, and oxygen if there is difficulty in breathing;" "where the platelet count drops to 47,000, dengue fever is foremost in physician's mind, and the management should be fresh blood infusion and supportive measures like oxygen and inhalation;" "that if presented with symptoms, tourniquet test and management is the proper treatment of this disease, and that it is possible that dengue fever could be detected earlier than 7:30 P.M. of April 23, 1988 because the symptoms were physically noted even by the parents and hospital personnel due to bleeding coupled with history of fever."*

the RTC that the petitioning doctors should not have solely relied on the chest-x-ray result, as it was not conclusive.

On SJDH's solidary liability, the CA ruled that the hospital's liability is based on Article 2180 of the Civil Code. The CA opined that the control which the hospital exercises over its consultants, the hospital's power to hire and terminate their services, all fulfill the employer-employee relationship requirement under Article 2180.

Lastly, the CA held that SJDH failed to adduce evidence showing that it exercised the diligence of a good father of a family in the hiring and the supervision of its physicians.

The petitioners separately moved to reconsider the CA decision, but the CA denied their motion in its resolution of January 12, 2006; hence, the present consolidated petitions pursuant to Rule 45 of the Rules of Court.

The Petitions

I. Dr. Casumpang's Position (G.R. No. 171127)

Dr. Casumpang contends that he gave his patient medical treatment and care to the best of his abilities, and within the proper standard of care required from physicians under similar circumstances. He claims that his initial diagnosis of bronchopneumonia was supported by the chest x-ray result.

Dr. Casumpang also contends that dengue fever occurs only after several days of confinement. He alleged that when he had suspected that Edmer might be suffering from dengue fever, he immediately attended and treated him.

Dr. Casumpang likewise raised serious doubts on Dr. Jaudian's credibility, arguing that the CA erred in appreciating his testimony as an expert witness since he lacked the necessary training, skills, and experience as a specialist in dengue fever cases.

II. Dr. Sanga's Position (G.R. No. 171217)

In her petition, Dr. Sanga faults the CA for holding her responsible for Edmer's wrong diagnosis, stressing that the function of making the diagnosis and undertaking the medical treatment devolved upon Dr. Casumpang, the doctor assigned to Edmer, and who confirmed "bronchopneumonia."

Dr. Sanga also alleged that she exercised prudence in performing her duties as a physician, underscoring that it was her professional intervention that led to the correct diagnosis of "*Dengue Hemorrhagic Fever*." Furthermore, Edmer's Complete Blood Count (*CBC*) showed leukopenia

and an increase in balance as shown by the differential count, demonstrating that Edmer's infection, more or less, is of bacterial and not viral in nature.

Dr. Sanga as well argued that there is no causal relation between the alleged erroneous diagnosis and medication for "*Bronchopneumonia*," and Edmer's death due to "*Dengue Hemorrhagic Fever*."

Lastly, she claimed that Dr. Jaudian is not a qualified expert witness since he never presented any evidence of formal residency training and fellowship status in Pediatrics.

III. SJDH's Position (G.R. No. 171228)

SJDH, on the other hand, disclaims liability by asserting that Dr. Casumpang and Dr. Sanga are mere independent contractors and "consultants" (not employees) of the hospital. SJDH alleges that since it did not exercise control or supervision over the consultants' exercise of medical profession, there is no employer-employee relationship between them, and consequently, Article 2180 of the Civil Code does not apply.

SJDH likewise anchored the absence of employer-employee relationship on the following circumstances: (1) SJDH does not hire consultants; it only grants them privileges to admit patients in the hospital through accreditation; (2) SJDH does not pay the consultants wages similar to an ordinary employee; (3) the consultants earn their own professional fees directly from their patients; SJDH does not fire or terminate their services; and (4) SJDH does not control or interfere with the manner and the means the consultants use in the treatment of their patients. It merely provides them with adequate space in exchange for rental payment.

Furthermore, SJDH claims that the CA erroneously applied the control test when it treated the hospital's practice of accrediting consultants as an exercise of control. It explained that the control contemplated by law is that which the employer exercises over the: *(i) end result*; and the (*ii) manner and means to be used to reach this end*, and not any kind of control, however significant, in accrediting the consultants.

SJDH moreover contends that even if the petitioning doctors are considered employees and not merely consultants of the hospital, SJDH cannot still be held solidarily liable under Article 2180 of the Civil Code because it observed the diligence of a good father of a family in their selection and supervision as shown by the following: (1) the adequate measures that the hospital undertakes to ascertain the petitioning doctors' qualifications and medical competence; and (2) the documentary evidence

that the petitioning doctors presented to prove their competence in the field of pediatrics.[27]

SJDH likewise faults the CA for ruling that the petitioning doctors are its agents, claiming that this theory, aside from being inconsistent with the CA's finding of employment relationship, is unfounded because: *first*, the petitioning doctors are independent contractors, not agents of SJDH; and *second*, as a medical institution, SJDH cannot practice medicine, much more, extend its personality to physicians to practice medicine on its behalf.

Lastly, SJDH maintains that the petitioning doctors arrived at an intelligently deduced and correct diagnosis. It claimed that based on Edmer's signs and symptoms *at the time of admission* (*i.e., one day fever*,[28] *bacterial infection*,[29] *and lack of hemorrhagic manifestations*[30]), there was no reasonable indication yet that he was suffering from dengue fever, and accordingly, their failure to diagnose dengue fever, does not constitute negligence on their part.

The Case for the Respondent

In his comment, the respondent submits that the issues the petitioners raised are mainly factual in nature, which a petition for review on *certiorari* under Rule 45 of the Rules of Courts does not allow.

In any case, he contends that the petitioning doctors were negligent in conducting their medical examination and diagnosis based on the following: (1) the petitioning doctors failed to timely diagnose Edmer's correct illness due to their non-observance of the proper and acceptable standard of medical examination; (2) the petitioning doctors' medical examination was not comprehensive, as they were always in a rush; and (3) the petitioning doctors employed a guessing game in diagnosing bronchopneumonia.

The respondent also alleges that there is a causal connection between the petitioning doctors' negligence and Edmer's untimely death, warranting the claim for damages.

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[27] *As to Dr. Casumpang: i. Certification of Residency in Pediatrics; ii. Certificate of Award certifying that he was considered to be the Most Outstanding Resident Physician in the Department of Pediatrics; and iii. Certificate of recognition as a Diplomate issued by the Philippine Pediatrics Society.*

As to Dr. Sanga: i. Board Examination Certificate showing that she passed the board examination; ii. Certification of Completion of Residency Training; and iii. Certificate of recognition as a Diplomate in Pediatrics. (per rollo, G.R. No. 171228, pp. 42-43)

[28] *As stated by Dr. Sanga, and as SJDH claims, dengue manifests as a high grade fever that is continuous for two (2) to seven (7) days. In this case, the petitioner doctors were presented with a patient with a clinical history of one day fever. (per rollo, G.R. No. 171228, pp. 56-57).*

[29] *In its petition, SJDH claimed that as opposed to Edmer's white blood cell (WBC) profile indicating a bacterial infection, dengue fever is caused not by a bacterium, but by a virus. (per rollo, G.R. No. 171228, pp. 56-57).*

[30] *SJDH substantiated its claim that there were no indications of dengue fever yet at the time of Edmer's admission by claiming that the latter was not hemoconcentrated and did not have thrombocytopenia. It also claimed that Edmer had no hemorrhagic manifestations at the time of his admission and until the following day. (per rollo, G.R. No. 171228, pp. 56-58).*

The respondent, too, asserted that SJDH is also negligent because it was not equipped with proper paging system, has no bronchoscope, and its doctors are not proportionate to the number of its patients. He also pointed out that out of the seven resident physicians in the hospital, only two resident physicians were doing rounds at the time of his son's confinement.

The Issues

The case presents to us the following issues:

1. Whether or not the petitioning doctors had committed "inexcusable lack of precaution" in diagnosing and in treating the patient;

2. Whether or not the petitioner hospital is solidarily liable with the petitioning doctors;

3. Whether or not there is a causal connection between the petitioners' negligent act/omission and the patient's resulting death; and

4. Whether or not the lower courts erred in considering Dr. Rodolfo Tabangcora Jaudian as an expert witness.

Our Ruling

We find the petition partly meritorious.

A Petition for Review on Certiorari under Rule 45 of the Rules of Court is Limited to Questions of Law.

The settled rule is that the Court's jurisdiction in a petition for review on *certiorari* under Rule 45 of the Rules of Court is limited only to the review of pure questions of law. It is not the Court's function to inquire on the veracity of the appellate court's factual findings and conclusions; this Court is not a trier of facts. [31]

A question of law arises when there is doubt as to what the law is on a certain state of facts, while there is a question of fact when the doubt arises as to the truth or falsity of the alleged facts.[32]

These consolidated petitions before us involve **mixed questions of fact and law**. As a rule, we do not resolve questions of fact. However, in determining the legal question of whether the respondent is entitled to claim damages under Article 2176 of the Civil Code for the petitioners' alleged

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[31] *First Metro Investment Corporation v. Este Del Sol Mountain Reserve, Inc., et al.*, 420 Phil. 902, 914 (2001).

[32] *Land Bank of the Philippines v. Yatco Agricultural Enterprises*, G.R. No.172551, January 15, 2014, 713 SCRA 370, 379.

medical malpractice, the determination of the factual issues – *i.e., whether the petitioning doctors were grossly negligent in diagnosing the patient's illness, whether there is causal relation between the petitioners' act/omission and the patient's resulting death, and whether Dr. Jaudian is qualified as an expert witness* – must necessarily be resolved. We resolve these factual questions solely for the purpose of determining the legal issues raised.

Medical Malpractice Suit as a Specialized Area of Tort Law

The claim for damages is based on the petitioning doctors' negligence in diagnosing and treating the deceased Edmer, the child of the respondent. It is a ***medical malpractice suit,*** an action available to victims to redress a wrong committed by medical professionals who caused bodily harm to, or the death of, a patient.[33] As the term is used, the suit is brought whenever a medical practitioner or health care provider fails to meet the standards demanded by his profession, or deviates from this standard, and causes injury to the patient.

To successfully pursue a medical malpractice suit, the plaintiff (*in this case, the deceased patient's heir*) must prove that the doctor either failed to do what a reasonably prudent doctor would have done, or did what a reasonably prudent doctor would not have done; and the act or omission had caused injury to the patient.[34] The patient's heir/s bears the burden of proving his/her cause of action.

The Elements of a Medical Malpractice Suit

The elements of medical negligence are: **(1) duty; (2) breach; (3) injury; and (4) proximate causation.**

Duty refers to the standard of behavior that imposes restrictions on one's conduct.[35] It requires proof of professional relationship between the physician and the patient. Without the professional relationship, a physician owes no duty to the patient, and cannot therefore incur any liability.

A physician-patient relationship is created when a patient engages the services of a physician,[36] and the latter accepts or agrees to provide care to the patient.[37] The establishment of this relationship is consensual,[38] and the acceptance by the physician essential. The mere fact that an individual

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33 *Spouses Flores v. Spouses Pineda*, 591 Phil. 699, 706 (2008).
34 *Garcia-Rueda v. Pascasio*, 344 Phil. 323, 331 (1997).
35 Martin, C.R.A., *Law Relating to Medical Malpractice* (2nd Ed.), p. 361.
36 *Lucas v. Tuaño*, 604 Phil. 98, 121 (2009).
37 61 Am Jur 2d §130 p. 247.
38 *Findlay v. Board of Supervisors of Mohave County*, 72 Ariz 58, 230 P2.d 526, 24 A.L.R.2d.

approaches a physician and seeks diagnosis, advice or treatment does not create the duty of care unless the physician agrees.[39]

The consent needed to create the relationship does not always need to be express.[40] In the absence of an express agreement, a physician-patient relationship may be implied from the physician's affirmative action to diagnose and/or treat a patient, or in his participation in such diagnosis and/or treatment.[41] The usual illustration would be the case of a patient who goes to a hospital or a clinic, and is examined and treated by the doctor. In this case, we can infer, based on the established and customary practice in the medical community that a patient-physician relationship exists.

Once a physician-patient relationship is established, the legal duty of care follows. The doctor accordingly becomes duty-bound to use at least the same standard of care that a reasonably competent doctor would use to treat a medical condition under similar circumstances.

Breach of duty occurs when the doctor fails to comply with, or improperly performs his duties under professional standards. This determination is both factual and legal, and is specific to each individual case.[42]

If the patient, as a result of the breach of duty, is injured in body or in health, actionable malpractice is committed, entitling the patient to damages.[43]

To successfully claim damages, the patient must lastly prove the causal relation between the negligence and the injury. This connection must be direct, natural, and should be unbroken by any intervening efficient causes. In other words, **the negligence must be the proximate cause of the injury.**[44] The injury or damage is proximately caused by the physician's negligence when it appears, based on the evidence and the expert testimony, that the negligence played an integral part in causing the injury or damage, and that the injury or damage was either a direct result, or a reasonably probable consequence of the physician's negligence.[45]

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39 Basic Elements of the Legal System of Physician Liability for Negligent Patient Injury in the United States With Comparisons to England and Canada. Frank G. Feeley, Wendy K. Mariner, 4 February 2000, http://dcc2.bumc.bu.edu/RussianLegalHealthReform/ProjectDocuments/n740.IIG.Bkgd.pdf.

40 Problems in Health Care Law, Robert Miller, Rebecca C. Hutton, 8th Edition.

41 *Kelley v. Middle Tennessee Emergency Physicians*, 133 SW3d 587, 596 (Tenn 2004).

42 Basic Elements of the Legal System of Physician Liability for Negligent Patient Injury in the United States With Comparisons to England and Canada. Frank G. Feeley, Wendy K. Mariner, 4 February 2000, http://dcc2.bumc.bu.edu/RussianLegalHealthReform/ProjectDocuments/n740.IIG.Bkgd.pdf.

43 *Supra* note 33.

44 *Jarcia, Jr. v. People of the Philippines*, G.R. No. 187926, February 15, 2012, 666 SCRA 336, 351-359.

45 Dissecting Philippine Law and Jurisprudence on Medical Malpractice, Darwin P. Angeles, A Framework of Philippine Medical Malpractice Law, 85 PHIL. L.J. 895, (2011).

a. The Relationship Between Dr. Casumpang and Edmer

In the present case, the physician-patient relationship between Dr. Casumpang and Edmer was created when the latter's parents sought the medical services of Dr. Casumpang, and the latter knowingly accepted Edmer as a patient. Dr. Casumpang's acceptance is implied from his affirmative examination, diagnosis and treatment of Edmer. On the other hand, Edmer's parents, on their son's behalf, manifested their consent by availing of the benefits of their health care plan, and by accepting the hospital's assigned doctor without objections.

b. The Relationship Between Dr. Sanga and Edmer

With respect to Dr. Sanga, her professional relationship with Edmer arose when she assumed the obligation to provide resident supervision over the latter. As second year resident doctor tasked to do rounds and assist other physicians, Dr. Sanga is deemed to have agreed to the creation of physician-patient relationship with the hospital's patients when she participated in the diagnosis and prescribed a course of treatment for Edmer.

The undisputed evidence shows that Dr. Sanga examined Edmer twice (*at around 12:00 and 3:30 in the afternoon of April 23, 1988*), and in both instances, she prescribed treatment and participated in the diagnosis of Edmer's medical condition. Her affirmative acts amounted to her acceptance of the physician-patient relationship, and incidentally, the legal duty of care that went with it.

In *Jarcia, Jr. v. People of the Philippines*,[46] the Court found the doctors who merely passed by and were requested to attend to the patient, liable for medical malpractice. It held that a physician-patient relationship was established when they examined the patient, and later assured the mother that everything was fine.

In the US case of *Mead v. Legacy Health System*,[47] the Court also considered the rendering of an opinion in the course of the patient's care as the doctor's assent to the physician-patient relationship. It ruled that the relationship was formed because of the doctor's affirmative action.

Likewise, in *Wax v. Johnson*,[48] the court found that a physician-patient relationship was formed between a physician who "contracts, agrees, undertakes, or otherwise assumes" the obligation to provide resident supervision at a teaching hospital, and the patient with whom the doctor had no direct or indirect contract.

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46 *Supra* note 44.
47 231, Or App 451, 220 P3d 118 (Or 2009).
48 42 SW3d 168 (Tex App- Houston 1st Dist 2001).

Standard of Care and Breach of Duty

A determination of whether or not the petitioning doctors met the required standard of care involves a question of mixed fact and law; it is **factual** as medical negligence cases are highly technical in nature, requiring the presentation of expert witnesses to provide guidance to the court on matters clearly falling within the domain of medical science, **and legal**, insofar as the Court, after evaluating the expert testimonies, and guided by medical literature, learned treatises, and its fund of common knowledge, ultimately determines whether breach of duty took place.

Whether or not Dr. Casumpang and Dr. Sanga committed a breach of duty is to be measured by the yardstick of professional standards observed by the other members of the medical profession in good standing under similar circumstances.[49] It is in this aspect of medical malpractice that expert testimony is essential to establish not only the professional standards observed in the medical community, but also that the physician's conduct in the treatment of care falls below such standard.[50]

In the present case, expert testimony is crucial in determining ***first***, *the standard medical examinations, tests, and procedures that the attending physicians should have undertaken in the diagnosis and treatment of dengue fever; and* ***second****, the dengue fever signs and symptoms that the attending physicians should have noticed and considered.*

Both the RTC and the CA relied largely on Dr. Jaudian's expert testimony on dengue diagnosis and management to support their finding that the petitioning doctors were guilty of breach of duty of care.

Dr. Jaudian testified that Edmer's rapid breathing, chest and stomach pain, fever, and the presence of blood in his saliva are classic symptoms of dengue fever. According to him, if the patient was admitted for chest pain, abdominal pain, and difficulty in breathing coupled with fever, dengue fever should definitely be considered;[51] if the patient spits coffee ground with the presence of blood, and the patient's platelet count drops to 47,000, it becomes a clear case of dengue fever, and bronchopneumonia can be reasonably ruled out.[52]

Furthermore, the standard of care according to Dr. Jaudian is to administer oxygen inhalation, analgesic, and fluid infusion or dextrose.[53] If the patient had twice vomited fresh blood and thrombocytopenia has already occurred, the doctor should order *blood transfusion, monitoring of the*

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49 *Cruz v. Court of Appeals*, 346 Phil. 872, 883 (1997).
50 *Solidum v. People*, G.R. No. 192123, March 10, 2014.
51 TSN, January 30, 1992, p. 11.
52 Id.
53 Id. at 15.

patient every 30 minutes, hemostatic to stop bleeding, and oxygen if there is difficulty in breathing.[54]

We find that Dr. Casumpang, as Edmer's attending physician, did not act according to these standards and, hence, was guilty of breach of duty. We do not find Dr. Sanga liable for the reasons discussed below.

Dr. Casumpang's Negligence

a. Negligence in the Diagnosis

At the trial, Dr. Casumpang declared that a doctor's impression regarding a patient's illness is 90% based on the physical examination, the information given by the patient or the latter's parents, and the patient's medical history.[55] He testified that he did not consider either dengue fever or dengue hemorrhagic fever because the patient's history showed that Edmer had low breath and voluntary submission, and that he was up and about playing basketball.[56] He based his diagnosis of bronchopneumonia on the following observations: "*difficulty in breathing, clearing run nostril, harsh breath sound, tight air, and sivilant sound*."[57]

It will be recalled that during Dr. Casumpang's first and second visits to Edmer, he already had knowledge of Edmer's laboratory test result (CBC), medical history, and symptoms (*i.e., fever, rashes, rapid breathing, chest and stomach pain, throat irritation, difficulty in breathing, and traces of blood in the sputum*). **However, these information did not lead Dr. Casumpang to the possibility that Edmer could be suffering from <u>either dengue fever, or dengue hemorrhagic fever</u>, as he clung to his diagnosis of broncho pneumonia.** This means that given the symptoms exhibited, Dr. Casumpang already ruled out the possibility of other diseases like dengue.

In other words, it was lost on Dr. Casumpang that the characteristic symptoms of dengue (as Dr. Jaudian testified) are: *patient's rapid breathing; chest and stomach pain; fever; and the presence of blood in his saliva.* All these manifestations were present and known to Dr. Casumpang at the time of his first and second visits to Edmer. While he noted some of these symptoms in confirming bronchopneumonia, he did not seem to have considered the patient's other manifestations in ruling out dengue fever or dengue hemorrhagic fever.[58] To our mind, Dr. Casumpang selectively appreciated some, and not all of the symptoms; worse, he casually ignored the pieces of information that could have been material in detecting dengue fever. This is evident from the testimony of Mrs. Cortejo:

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54 Id.
55 Id. at 10.
56 Id.
57 Id. at 8.
58 Id. at 11-13.

TSN, Mrs. Cortejo, November 27, 1990

Q: Now, when Dr. Casumpang visited your son for the first time at 5:30 p.m., what did he do, if any?
A: He examined my son by using stethoscope and after that, he confirmed to me that my son was suffering from broncho pneumonia.
Q: After he confirmed that your son was suffering broncho **pneumonia, what did you say if any?**
A: Again, I told Dr. Casumpang, how come it was broncho pneumonia when my son has no cough or colds.
Q: What was the answer of Dr. Casumpang to your statement?

x x x x

A: And then, Dr. Casumpang answered "THAT'S THE USUAL BRONCHO PNEUMONIA, NO COLDS, NO PHLEGM."
Q: How long did Dr. Casumpang stay in your son's room?
A: He stayed for a minute or 2.

x x x x

Q: When Dr. Casumpang arrived at 9:00 o'clock a.m. on April 23, what did you tell him, if any?

x x x x

A: I told Dr. Casumpang… After examining my son using stethoscope and nothing more, I told Dr. Casumpang about the traces of blood in my son's sputum and I told him what is all about and he has throat irritation.
Q: What did he tell you?
A: He just nodded his head but he did not take the initiative of looking at the throat of my son.
Q: So what happened after that?
A: I also told Dr. Casumpang about his chest pain and also stomach pain.
Q: So what did Dr. Casumpang do after you have narrated all these complaints of your son?
A: Nothing. He also noticed the rapid breathing of my son and my son was almost moving because of rapid breathing and he is swaying in the bed.
Q: Do you know what action was taken by Dr. Casumpang when you told him that your son is experiencing a rapid breathing?
A: No action. He just asked me if my son has an asthma but I said none.
Q: So how long did Dr. Casumpang stay and attended your son on April 23?
A: More or less two (2) minutes then I followed him up to the door and I repeated about the fever of my son.
Q: What did he tell you, if any, regarding that information you gave him that your son had a fever?
A: He said, that is broncho pneumonia, It's only being active now. [Emphasis supplied]

We also find it strange why Dr. Casumpang did not even bother to check Edmer's throat despite knowing that as early as 9:00 in the morning of

April 23, 1988, Edmer had blood streaks in his sputum. Neither did Dr. Casumpang order confirmatory tests to confirm the source of bleeding. The Physician's Progress Notes[59] stated: "*Blood streaks on phlegm can be due to bronchial irritation or congestion*," which clearly showed that Dr. Casumpang merely assumed, without confirmatory physical examination, that bronchopneumonia caused the bleeding.

Dr. Jaudian likewise opined that Dr. Casumpang's medical examination was not comprehensive enough to reasonably lead to a correct diagnosis.[60] Dr. Casumpang only used a stethoscope in coming up with the diagnosis that Edmer was suffering from bronchopneumonia; he never confirmed this finding with the use of a bronchoscope. Furthermore, Dr. Casumpang based his diagnosis largely on the chest x-ray result that is generally inconclusive.[61]

Significantly, it was only at around 5:00 in the afternoon of April 23, 1988 (after Edmer's third episode of bleeding) that Dr. Casumpang ordered the conduct of *hematocrit, hemoglobin, blood typing, blood transfusion and tourniquet tests*. These tests came too late, as proven by: (1) the blood test results that came at about 6:00 in the evening, confirming that Edmer's illness had developed to "*Dengue Hemorrhagic Fever*;" and (2) Dr. Jaudian's testimony that "*dengue fever could have been detected earlier than 7:30 in the evening of April 23, 1988 because the symptoms were already evident.*"[62]

In *Spouses Flores v. Spouses Pineda*,[63] a case involving a medical malpractice suit, the Court ruled that the petitioner doctors were negligent because they failed to immediately order tests to confirm the patient's illness. Despite the doctors' suspicion that the patient could be suffering from diabetes, the former still proceeded to the D&C operation. In that case, expert testimony showed that tests should have been ordered immediately on admission to the hospital in view of the symptoms presented. The Court held:

> When a patient exhibits symptoms typical of a particular disease, these symptoms should, at the very least, alert the physician of the possibility that the patient may be afflicted with the suspected disease.

The Court also ruled that reasonable prudence would have shown that diabetes and its complications were foreseeable harm. However, the petitioner doctors failed to take this into consideration and proceeded with the D&C operation. Thus, the Court ruled that they failed to comply with their duty to observe the standard of care to be given to hyperglycemic/diabetic patients.

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59 *Rollo*, (G.R. No. 171228) pp. 263-265.
60 *Rollo*, (G.R. No. 171127) p. 62.
61 Id. at 64-65.
62 TSN, February 27, 1992, p. 8.
63 *Supra* note 33.

Similarly, in *Jarcia*,[64] involving the negligence of the doctors in failing to exercise reasonable prudence in ascertaining the extent of the patient's injuries, this Court declared that:

> **In failing to perform an extensive medical examination to determine the extent of Roy Jr.'s injuries, Dr. Jarcia and Dr. Bastan were remiss of their duties as members of the medical profession.** Assuming for the sake of argument that they did not have the capacity to make such thorough evaluation at that stage, they should have referred the patient to another doctor with sufficient training and experience instead of assuring him and his mother that everything was all right. [Emphasis supplied]

Even assuming that Edmer's symptoms completely coincided with the diagnosis of bronchopneumonia (so that this diagnosis could not be considered "wrong"), we still find Dr. Casumpang guilty of negligence.

First, **we emphasize that we do not decide the correctness of a doctor's diagnosis, or the accuracy of the medical findings and treatment.** Our duty in medical malpractice cases is to decide – *based on the evidence adduced and expert opinion presented* – whether a breach of duty took place.

Second, **we clarify that a wrong diagnosis is not by itself medical malpractice**.[65] Physicians are generally not liable for damages resulting from a *bona fide* error of judgment. Nonetheless, when the physician's erroneous diagnosis was the result of negligent conduct (*e.g., neglect of medical history, failure to order the appropriate tests, failure to recognize symptoms*), it becomes an evidence of medical malpractice.

Third, we also note that medicine is not an exact science;[66] and doctors, or even specialists, are not expected to give a 100% accurate diagnosis in treating patients who come to their clinic for consultations. Error is possible as the exercise of judgment is called for in considering and reading the exhibited symptoms, the results of tests, and in arriving at definitive conclusions. But in doing all these, the doctor must have acted according to acceptable medical practice standards.

In the present case, evidence on record established that in confirming the diagnosis of bronchopneumonia, Dr. Casumpang selectively appreciated some and not all of the symptoms presented, and failed to promptly conduct the appropriate tests to confirm his findings. In sum, Dr. Casumpang failed to timely detect dengue fever, which failure, *especially when reasonable prudence would have shown that indications of dengue were evident and/or foreseeable*, constitutes negligence.

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64 *Supra* note 44. This is a criminal case for reckless imprudence resulting to serious physical injuries filed against Dr. Jarcia, Dr. Bastan, and Dr. Pamittan.

65 61 Am Jur 2d, 190; The question in professional malpractice suits is not whether a physician had made a mistake but whether he or she used ordinary care.

66 22A Am Jur 2d, 570.

a. Negligence in the Treatment and Management of Dengue

Apart from ***failing to promptly detect*** dengue fever, Dr. Casumpang also ***failed*** to promptly ***undertake the proper medical management*** needed for this disease.

As Dr. Jaudian opined, the standard medical procedure once the patient had exhibited the classic symptoms of dengue fever should have been: *oxygen inhalation, use of analgesic, and infusion of fluids or dextrose*;[67] and once the patient had twice vomited fresh blood, the doctor should have ordered: *blood transfusion, monitoring of the patient every 30 minutes, hemostatic to stop bleeding, and oxygen if there is difficulty in breathing*.[68]

Dr. Casumpang failed to measure up to these standards. The evidence strongly suggests that he ordered a transfusion of platelet concentrate instead of blood transfusion. The tourniquet test was only conducted after Edmer's second episode of bleeding, and the medical management (as reflected in the records) did not include antibiotic therapy and complete physical examination.

Dr. Casumpang's testimony states:

Q: Now, after entertaining – After considering that the patient Edmer Cortero was already suffering from dengue hemorrhagic fever, what did you do, if any?
A: We ordered close monitoring of the blood pressure, the cardiac rate and respiratory rate of the patient.
Q: Now, was your instructions carried on?
A: Yes, sir.
Q: What was the blood pressure of the patient?
A: During those times, the blood pressure of the patient was even normal during those times.
Q: How about the respiratory rate?
A: The respiratory rate was fast because the patient in the beginning since admission had difficulty in breathing.
Q: Then, after that, what did you do with the patient? Doctor?
A: We transfused platelet concentrate and at the same time, we monitor [*sic*] the patient.
Q: Then, who monitor [*sic*] the patient?
A: The pediatric resident on duty at that time.
Q: Now, what happened after that?
Q: While monitoring the patient, all his vital signs were _____; his blood pressure was normal so we continued with the supportive management at that time.
Q: Now, after that?
A: In the evening of April 23, 1988, I stayed in the hospital and I was informed by the pediatric resident on duty at around 11:15 in the evening that the blood pressure of the patient went down to .60 palpatory.

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67 TSN, January 30, 1992, p. 15 (per *rollo*, G.R. No. 171228, p. 82).
68 Id.

> **Q: What did you do upon receipt of that information?**
> **A: I immediately went up to the room of the patient and we changed the IV fluid from the present fluid which was D5 0.3 sodium chloride to lactated ringers solution.**
> **Q: You mean to say you increased the dengue [*sic*] of the intervenus [*sic*] fluid?**
> **A: We changed the IV fluid because lactated ringers was necessary to resume the volume and to bring back the blood pressure, to increase the blood pressure.** [Emphasis supplied]

Although Dr. Casumpang presented the testimonies of Dr. Rodolfo Jagonap and Dr. Ellewelyn Pasion (*Dr. Pasion*), Personnel Officer and Medical Director of SJDH, respectively as well as the testimonies of Dr. Livelo and Dr. Reyes (the radiologist who read Edmer's chest x-ray result), these witnesses failed to dispute the standard of action that Dr. Jaudian established in his expert opinion. We cannot consider them expert witnesses either for the sole reason that they did not testify on the standard of care in dengue cases.[69]

On the whole, after examining the totality of the adduced evidence, we find that the lower courts correctly did not rely on Dr. Casumpang's claim that he exercised prudence and due diligence in handling Edmer's case. Aside from being self-serving, his claim is not supported by competent evidence. As the lower courts did, we rely on the uncontroverted fact that he failed, as a medical professional, to observe the most prudent medical procedure under the circumstances in diagnosing and treating Edmer.

Dr. Sanga is Not Liable for Negligence

In considering the case of Dr. Sanga, the junior resident physician who was on-duty at the time of Edmer's confinement, we see the need to draw distinctions between the responsibilities and corresponding liability of Dr. Casumpang, as the attending physician, and that of Dr. Sanga.

In his testimony, Dr. Pasion declared that resident applicants are generally doctors of medicine licensed to practice in the Philippines and who would like to pursue a particular specialty.[70] They are usually the front line doctors responsible for the first contact with the patient. During the scope of the residency program,[71] resident physicians (or "residents")[72] function under the supervision of attending physicians[73] or of the hospital's teaching staff. Under this arrangement, residents operate merely as subordinates who

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69 These witnesses were presented as ordinary witnesses.

70 TSN, January 26, 1993, p. 6.

71 Residency is a period of advanced medical training and education that normally follows graduation from medical school and licensing to practice medicine and that consists of a specialty in a hospital and in its outpatient department and instruction from specialists on the hospital staff. Merriam-Webster's Medical Dictionary, p. 648.

72 A physician serving a residency; Merriam-Webster's Medical Dictionary, p. 648.

73 A physician or surgeon on the staff of a hospital, regularly visiting and treating patients, and often supervising students, fellows, and the house staff; Merriam-Webster's Medical Dictionary, p. 58.

usually defer to the attending physician on the decision to be made and on the action to be taken.

The attending physician, on the other hand, is primarily responsible for managing the resident's exercise of duties. While attending and resident physicians share the collective responsibility to deliver safe and appropriate care to the patients,[74] it is the attending physician who assumes the principal responsibility of patient care.[75] Because he/she exercises a supervisory role over the resident, and is ultimately responsible for the diagnosis and treatment of the patient, the standards applicable to and the liability of the resident for medical malpractice is theoretically less than that of the attending physician. These relative burdens and distinctions, however, do not translate to immunity from the legal duty of care for residents,[76] or from the responsibility arising from their own negligent act.

In *Jenkins v. Clark*,[77] the Ohio Court of Appeals held that the applicable standard of care in medical malpractice cases involving first-year residents was that of a reasonably prudent physician and not that of interns. According to *Jenkins*:

> It is clear that the standard of care required of physicians is not an individualized one but of physicians in general in the community. In order to establish medical malpractice, it must be shown by a preponderance of the evidence that a physician did some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would not have done under like or similar conditions or circumstances, or that he failed or omitted to do some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would have done under like or similar conditions or circumstances, and that the inquiry complained of was the direct result of such doing or failing to do such thing or things.
>
> We note that the standard of instruction given by the court was indeed a proper one. **It clearly informed the jury that the medical care required is that of reasonably careful physicians or hospital emergency room operators, not of interns or residents**. [Emphasis supplied]

A decade later, *Centman v. Cobb*,[78] affirmed the *Jenkins* ruling and held that interns and first-year residents are "*practitioners of medicine required to exercise the same standard of care applicable to physicians with unlimited licenses to practice*." The Indiana Court held that although a first-year resident practices under a temporary medical permit, he/she impliedly contracts that he/she has the reasonable and ordinary qualifications of her profession and that he/she will exercise reasonable skill, diligence, and care in treating the patient.

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74 Professional Liability Issues in Graduate Medical Institution, www.Ncbi.nlm.nih.gov/pubmed/15339896.

75 755 ILCS 35/2(a); Illinois Jurisprudence, Health Law.

76 *Mercil v. Mathers*, No. C3-93-140, 1994 WL 1114 (Minn Ct App Jan. 4, 1994).

77 7 Ohio App. 3d 93, 101 (1982).

78 581 N.E.2d 1286 (Ind Ct App 1991).

We find that Dr. Sanga was not independently negligent. Although she had greater patient exposure, and was subject to the same standard of care applicable to attending physicians, we believe that a finding of negligence should also depend on several competing factors, among them, *her authority to make her own diagnosis, the degree of supervision of the attending physician over her, and the shared responsibility between her and the attending physicians*.

In this case, before Dr. Sanga attended to Edmer, both Dr. Livelo and Dr. Casumpang had diagnosed Edmer with bronchopneumonia. In her testimony, Dr. Sanga admitted that she had been briefed about Edmer's condition, his medical history, and initial diagnosis;[79] and based on these pieces of information, she *confirmed* the finding of bronchopneumonia.

Dr. Sanga likewise duly reported to Dr. Casumpang, who admitted receiving updates regarding Edmer's condition.[80] There is also evidence supporting Dr. Sanga's claim that she extended diligent care to Edmer. In fact, when she suspected – *during Edmer's second episode of bleeding* – that Edmer could be suffering from dengue fever, she wasted no time in conducting the necessary tests, and promptly notified Dr. Casumpang about the incident. Indubitably, her medical assistance led to the finding of dengue fever.

We note however, that during Edmer's second episode of bleeding,[81] Dr. Sanga failed to immediately examine and note the cause of the blood specimen. Like Dr. Casumpang, she merely assumed that the blood in Edmer's phlegm was caused by bronchopneumonia. Her testimony states:

> **TSN, June 8, 1993:**
>
> Q: Let us get this clear, you said that the father told you the patient cocked [*sic*] out phlegm.
> A: With blood streak.
> **Q: Now, you stated specimen, were you not able to examine the specimen?**
> **A: No, sir, I did not because according to the father he wash [*sic*] his hands.**
>
> x x x x
>
> Q: Now, from you knowledge, what does that indicate if the patient expels a phlegm and blood streak?
> A: If a patient cocked [*sic*] out phlegm then the specimen could have come from the lung alone.[82] [Emphasis supplied]
>
> x x x x

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79 TSN, June 8, 1993, pp. 11-13.
80 TSN, March 2, 1993, pp. 23, 31-33; April 1, 1993, p. 6.
81 At 11:30 in the morning of April 23, 1988.
82 TSN, June 8, 1993, p. 16.

TSN, June 17, 1993:

Q: Now, in the first meeting you had, when that was relayed to you by the father that Edmer Cortejo had coughed out blood, what medical action did you take?
A: I examined the patient and I thought that, that coughed out phlegm was a product of broncho pneumonia.

x x x x

Q: So what examination did you specifically conduct to see that there was no internal bleeding?
A: At that time I did not do anything to determine the cause of coughing of the blood because <u>I presumed</u> that it was a mucous (sic) produced by broncho pneumonia, And besides the patient did not even show any signs of any other illness at that time.[83]

Based on her statements we find that Dr. Sanga was not entirely faultless. **Nevertheless, her failure to discern the import of Edmer's second bleeding does not necessarily amount to negligence** as the respondent himself admitted that Dr. Sanga failed to examine the blood specimen because he washed it away. In addition, considering the diagnosis previously made by two doctors, and the uncontroverted fact that the burden of final diagnosis pertains to the attending physician (*in this case, Dr. Casumpang*), we believe that Dr. Sanga's error was merely an honest mistake of judgment influenced in no small measure by her status in the hospital hierarchy; hence, she should not be held liable for medical negligence.

Dr. Jaudian's Professional Competence and Credibility

One of the critical issues the petitioners raised in the proceedings before the lower court and before this Court was Dr. Jaudian's competence and credibility as an expert witness. The petitioners tried to discredit his expert testimony on the ground that he lacked the proper training and fellowship status in pediatrics.

- *Criteria in Qualifying as an Expert Witness*

The competence of an expert witness is a matter for the trial court to decide upon in the exercise of its discretion. The test of qualification is necessarily a relative one, depending upon the subject matter of the investigation, and the fitness of the expert witness.[84] In our jurisdiction, the criterion remains to be the expert witness' **special knowledge experience and practical training that qualify him/her to explain highly technical medical matters to the Court**.

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83 TSN, June 17, 1993, pp. 27-28.
84 *Tomasa vda. De Jacob v. Court of Appeals*, 371 Phil. 693, 709 (1999).

In *Ramos v. Court of Appeals*,[85] the Court found the expert witness, who is a pulmonologist, not qualified to testify on the field of anesthesiology. Similarly, in *Cereno v. Court of Appeals*,[86] a 2012 case involving medical negligence, the Court excluded the testimony of an expert witness whose specialty was anesthesiology, and concluded that an anesthesiologist cannot be considered an expert in the field of surgery or even in surgical practices and diagnosis.

Interestingly in this case, Dr. Jaudian, the expert witness was admittedly not a pediatrician but a practicing physician who specializes in pathology.[87] He likewise does not possess any formal residency training in pediatrics. Nonetheless, both the lower courts found his knowledge acquired through study and practical experience sufficient to advance an expert opinion on dengue-related cases.

We agree with the lower courts.

A close scrutiny of *Ramos* and *Cereno* reveals that the Court primarily based the witnesses' disqualification to testify as an expert on their *incapacity to shed light on the standard of care that must be observed by the defendant-physicians*. That the expert witnesses' specialties do not match the physicians' practice area only constituted, at most, one of the considerations that should not be taken out of context. After all, the sole function of a medical expert witness, regardless of his/her specialty, is to afford assistance to the courts on medical matters, and to explain the medical facts in issue.

Furthermore, there was no reasonable indication in *Ramos* and *Cereno* that the expert witnesses possess a sufficient familiarity with the standard of care applicable to the physicians' specialties.

US jurisprudence on medical malpractice demonstrated the trial courts' wide latitude of discretion in allowing a specialist from another field to testify against a defendant specialist.

In *Brown v. Sims*,[88] a neurosurgeon was found competent to give expert testimony regarding a gynecologist's standard of pre-surgical care. In that case, the court held that since negligence was not predicated on the gynecologist's negligent performance of the operation, but primarily on the claim that the pre-operative histories and physicals were inadequate, the neurosurgeon was competent to testify as an expert.

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85 378 Phil. 1198 (1999).

86 G.R. No. 167366, September 26, 2012, 682 SCRA 18.

87 Pathology is the study of diseases, their essential nature, causes, and development, and the structural and functional changes produced by them. (Webster's Third New International Dictionary, p. 1655).

88 538 So. 2d 901 (Fla. Dist. Ct. App. 1989).

Frost v. Mayo Clinic[89] also allowed an orthopedic surgeon to testify against a neurologist in a medical malpractice action. The court considered that the orthopedic surgeon's opinion on the "immediate need for decompression" need not come from a specialist in neurosurgery. The court held that:

> It is well established that "the testimony of a qualified medical doctor cannot be excluded simply because he is not a specialist x x x." The matter of "x x x training and specialization of the witness goes to the weight rather than admissibility x x x."
>
> x x x x
>
> It did not appear to the court that a medical doctor had to be a specialist in neurosurgery to express the opinions permitted to be expressed by plaintiffs' doctors, *e.g.*, the immediate need for a decompression in the light of certain neurological deficits in a post-laminectomy patient. As stated above, there was no issue as to the proper execution of the neurosurgery. The medical testimony supported plaintiffs' theory of negligence and causation. (Citations omitted)

In another case,[90] the court declared that it is the **specialist's knowledge of the requisite subject matter, rather than his/her specialty that determines his/her qualification to testify**.

Also in *Evans v. Ohanesian*,[91] the court set a guideline in qualifying an expert witness:

> To qualify a witness as a medical expert, it must be shown that the witness **(1) has the required professional knowledge, learning and skill of the subject under inquiry sufficient to qualify him to speak with authority on the subject; and (2) is familiar with the standard required of a physician under similar circumstances**; where a witness has disclosed sufficient knowledge of the subject to entitle his opinion to go to the jury, the question of the degree of his knowledge goes more to the weight of the evidence than to its admissibility.
>
> x x x x
>
> Nor is it critical whether a medical expert is a general practitioner or a specialist **so long as he exhibits knowledge of the subject. Where a duly licensed and practicing physician has gained knowledge of the standard of care applicable to a specialty in which he is not directly engaged but as to which he has an opinion based on education, experience, observation, or association wit that specialty, his opinion is competent.** (Emphasis supplied)

Finally, *Brown v. Mladineo*[92] adhered to the principle that the witness' familiarity, and not the classification by title or specialty, which should control issues regarding the expert witness' qualifications:

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89 304 F. Supp. 285 (1969).

90 *McLean v. Hunter*, 495 So. 2d 1298 (1986).

91 39 Cal. App. 3d 121, 112 Cal. Rptr. 236 (1974). This is a dental medical malpractice suit brought against a practitioner of general dentistry.

> The general rule as to expert testimony in medical malpractice actions is that "a specialist in a particular branch within a profession will not be required." Most courts allow a doctor to testify if they are satisfied of his familiarity with the standards of a specialty, though he may not practice the specialty himself. One court explained that "it is the scope of the witness' knowledge and not the artificial classification by title that should govern the threshold question of admissibility. (Citations omitted)

- *Application to the Present Case*

In the case and the facts before us, we find that Dr. Jaudian is competent to testify on the standard of care in dengue fever cases.

Although he specializes in pathology, it was established during trial that he had attended not less than 30 seminars held by the Pediatric Society, had exposure in pediatrics, had been practicing medicine for 16 years, and had handled not less than 50 dengue related cases.

As a licensed medical practitioner specializing in pathology, who had practical and relevant exposure in pediatrics and dengue related cases, we are convinced that Dr. Jaudian demonstrated sufficient familiarity with the standard of care to be applied in dengue fever cases. Furthermore, we agree that he possesses knowledge and experience sufficient to qualify him to speak with authority on the subject.

The Causation Between Dr. Casumpang's Negligent Act/Omission, and the Patient's Resulting Death was Adequately Proven

Dr. Jaudian's testimony strongly suggests that due to Dr. Casumpang's failure to timely diagnose Edmer with dengue, the latter was not immediately given the proper treatment. In fact, even after Dr. Casumpang had discovered Edmer's real illness, he still failed to promptly perform the standard medical procedure. We agree with these findings.

As the respondent had pointed out, dengue fever, if left untreated, could be a life threatening disease. As in any fatal diseases, it requires immediate medical attention.[93] With the correct and timely diagnosis, coupled with the proper medical management, dengue fever is not a life-threatening disease and could easily be cured.[94]

Furthermore, as Dr. Jaudian testified, with adequate intensive care, the mortality rate of dengue fever should fall to less than 2%. Hence, the

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92 504 So. 2d. 1201 (1987). The issue involved in this case is whether the testimony of a pathologist-general surgeon may be admitted as expert testimony on the medical negligence of an OB-gynecologist.

93 *Rollo*, (G.R. No. 171127) p. 128.

94 Id. at 62.

survival of the patient is directly related to early and proper management of the illness.[95]

To reiterate, Dr. Casumpang failed to timely diagnose Edmer with dengue fever despite the presence of its characteristic symptoms; and as a consequence of the delayed diagnosis, he also failed to promptly manage Edmer's illness. Had he immediately conducted confirmatory tests, (*i.e., tourniquet tests and series of blood tests)* and promptly administered the proper care and management needed for dengue fever, the risk of complications or even death, could have been substantially reduced.

Furthermore, medical literature on dengue shows that early diagnosis and management of dengue is critical in reducing the risk of complications and avoiding further spread of the virus.[96] That Edmer later died of "Hypovolemic Shock/hemorrhagic shock," "Dengue Hemorrhagic Fever Stage IV," a severe and fatal form of dengue fever, established the causal link between Dr. Casumpang's negligence and the injury.

Based on these considerations, we rule that the respondent successfully proved the element of causation.

Liability of SJDH

We now discuss the liability of the hospital.

The respondent submits that SJDH should not only be held vicariously liable for the petitioning doctors' negligence but also for its own negligence. He claims that SJDH fell short of its duty of providing its patients with the necessary facilities and equipment as shown by the following circumstances:

(a) SJDH was not equipped with proper paging system;

(b) the number of its doctors is not proportionate to the number of patients;

(c) SJDH was not equipped with a bronchoscope;

(d) when Edmer's oxygen was removed, the medical staff did not immediately provide him with portable oxygen;

(e) when Edmer was about to be transferred to another hospital, SJDH's was not ready and had no driver; and

(f) despite Edmer's critical condition, there was no doctor attending to him from 5:30 p.m. of April 22, to 9:00 a.m. of April 23, 1988.

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95 TSN, February 27, 1992, p. 12.

96 WHO, Dengue and Severe Dengue; http://www.who.int/mediacentre/factsheets/fs117/en/.

SJDH on the other hand disclaims liability by claiming that the petitioning doctors are not its employees but are mere consultants and independent contractors.

We affirm the hospital's liability not on the basis of Article 2180 of the Civil Code, but on the basis of the doctrine of apparent authority or agency by estoppel.

There is No Employer-Employee Relationship Between SJDH and the Petitioning Doctors

In determining whether an employer-employee relationship exists between the parties, the following elements must be present: (1) selection and engagement of services; (2) payment of wages; (3) the power to hire and fire; and (4) the power to control not only the end to be achieved, but the means to be used in reaching such an end.[97]

Control, which is the most crucial among the elements, is not present in this case.

Based on the records, no evidence exists showing that SJDH exercised any degree of control over the means, methods of procedure and manner by which the petitioning doctors conducted and performed their medical profession. SJDH did not control their diagnosis and treatment. Likewise, no evidence was presented to show that SJDH monitored, supervised, or directed the petitioning doctors in the treatment and management of Edmer's case. In these lights, the petitioning doctors were not employees of SJDH, but were mere independent contractors.

SJDH is Solidarily Liable Based on The Principle of Agency or Doctrine of Apparent Authority

Despite the absence of employer-employee relationship between SJDH and the petitioning doctors, SJDH is not free from liability.[98]

As a rule, hospitals are not liable for the negligence of its independent contractors. However, it may be found liable if the physician or independent contractor acts as an ostensible agent of the hospital. This exception is also known as the "**doctrine of apparent authority.**"[99]

The US case of *Gilbert v. Sycamore Municipal Hospital*[100] abrogated the hospitals' immunity to vicarious liability of independent contractor physicians. In that case, the Illinois Supreme Court held that under the

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97 *Ramos v. Court of Appeals*, *supra* note 85.
98 *Nogales v. Capitol Medical Center*, 540 Phil. 225, 245-247 (2006).
99 Id.
100 156 Ill. 2d 511, 622 N.E. 2d 788 (1993).

doctrine of apparent authority, hospitals could be found vicariously liable for the negligence of an independent contractor:

> Therefore, we hold that, under the doctrine of apparent authority, a hospital can be held vicariously liable for the negligent acts of a physician providing care at the hospital, regardless of whether the physician is an independent contractor, unless the patient knows, or should have known, that the physician is an independent contractor. The elements of the action have been set out as follows:
>
> > For a hospital to be liable under the doctrine of apparent authority, a plaintiff must show that**: (1) the hospital, or its agent, acted in a manner that would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital; (2) where the acts of the agent create the appearance of authority, the plaintiff must also prove that the hospital had knowledge of and acquiesced in them; and (3) the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence. (Emphasis supplied)**

The doctrine was applied in *Nogales v. Capitol Medical Center*[101] where this Court, through the *ponencia* of Associate Justice Antonio T. Carpio, discussed the two factors in determining hospital liability as follows:

> The first factor focuses on the hospital's manifestations and is sometimes described as an inquiry whether the hospital acted in a manner which would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital. In this regard, the hospital need not make express representations to the patient that the treating physician is an employee of the hospital; rather a representation may be general and implied.
>
> x x x x
>
> The second factor focuses on the patient's reliance. It is sometimes characterized as an inquiry on whether the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence. (Citation omitted)

In sum, a hospital can be held vicariously liable for the negligent acts of a physician (or an independent contractor) providing care at the hospital if the plaintiff can prove these two factors: ***first****, the hospital's manifestations; and* ***second****, the patient's reliance.*

a. Hospital's manifestations

It involves an inquiry on whether the hospital acted in a manner that would lead a reasonable person to conclude that the individual alleged to be negligent was an employee or agent of the hospital. As pointed out in *Nogales*, the hospital need not make express representations to the patient

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101 *Supra* note 98, at 246.

that the physician or independent contractor is an employee of the hospital; representation may be general and implied.[102]

In *Pamperin v. Trinity Memorial Hospital*,[103] questions were raised on "what acts by the hospital or its agent are sufficient to lead a reasonable person to conclude that the individual was an agent of the hospital." In ruling that the hospital's manifestations can be proven without the express representation by the hospital, the court relied on several cases from other jurisdictions, and held that:

> (1) the hospital, by providing emergency room care and by failing to advise patients that they were being treated by the hospital's agent and not its employee, has created the appearance of agency; and
>
> (2) patients entering the hospital through the emergency room, could properly assume that the treating doctors and staff of the hospital were acting on its behalf.

In this case, the court considered the act of the hospital of holding itself out as provider of complete medical care, and considered the hospital to have impliedly created the appearance of authority.

b. Patient's reliance

It involves an inquiry on whether the plaintiff acted in reliance on the conduct of the hospital or its **agent**, consistent with ordinary care and prudence.[104]

In *Pamperin*, the court held that the important consideration in determining the patient's reliance is: *whether the plaintiff is seeking care from the hospital itself or whether the plaintiff is looking to the hospital merely as a place for his/her personal physician to provide medical care*.[105]

Thus, this requirement is deemed satisfied if the plaintiff can prove that he/she relied upon the hospital to provide care and treatment, rather than upon a specific physician. In this case, we shall limit the determination of the hospital's apparent authority to Dr. Casumpang, in view of our finding that Dr. Sanga is not liable for negligence.

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102 Id.

103 144 Wis. 2d 188, 207, 423 N.W. 2d. 848, 855 (1988).

104 *PSI v. CA*, 568 Phil. 158, 166-167 (2008), citing *Diggs v. Novant Health, Inc.*, 628 S.E.2d 851 (2006) and *Hylton v. Koontz*, 138 N.C. App. 629 (2000).

105 *Supra* note 103.

SJDH Clothed Dr. Casumpang With Apparent Authority

SJDH impliedly held out and clothed Dr. Casumpang with apparent authority leading the respondent to believe that he is an employee or agent of the hospital.

Based on the records, the respondent relied on SJDH rather than upon Dr. Casumpang, to care and treat his son Edmer. His testimony during trial showed that he and his wife did not know any doctors at SJDH**; they also did not know that Dr. Casumpang was an independent contractor.** They brought their son to SJDH for diagnosis because of their family doctor's referral. The referral did not specifically point to Dr. Casumpang or even to Dr. Sanga, but to SJDH.

Significantly, the respondent had relied on SJDH's representation of Dr. Casumpang's authority. To recall, when Mrs. Cortejo presented her Fortune Care card, she was initially referred to the Fortune Care coordinator, who was then out of town. She was thereafter referred to Dr. Casumpang, who is also accredited with Fortune Care. In both instances, SJDH through its agent failed to advise Mrs. Cortejo that Dr. Casumpang is an independent contractor.

Mrs. Cortejo accepted Dr. Casumpang's services on the reasonable belief that such were being provided by SJDH or its employees, agents, or servants. **By referring Dr. Casumpang to care and treat for Edmer, SJDH impliedly held out Dr. Casumpang, not only as an accredited member of Fortune Care, but also as a member of its medical staff.** SJDH cannot now disclaim liability since there is no showing that Mrs. Cortejo or the respondent knew, or should have known, that Dr. Casumpang is only an independent contractor of the hospital. In this case, estoppel has already set in.

We also stress that Mrs. Cortejo's use of health care plan (*Fortune Care*) did not affect SJDH's liability. The only effect of the availment of her Fortune Care card benefits is that her choice of physician is limited only to physicians who are accredited with Fortune Care. Thus, her use of health care plan in this case only limited the choice of doctors (*or coverage of services, amount etc.*) and not the liability of doctors or the hospital.

WHEREFORE, premises considered, this Court **PARTLY GRANTS** the consolidated petitions. The Court finds Dr. Noel Casumpang and San Juan de Dios Hospital solidarily liable for negligent medical practice. We **SET ASIDE** the finding of liability as to Dr. Ruby Miranda-Sanga. The amounts of ₱45,000.00 as actual damages and ₱500,000.00 as moral damages should each earn legal interest at the rate of six percent (6%) per annum computed from the date of the judgment of the trial court. The

Court **AFFIRMS** the rest of the Decision dated October 29, 2004 and the Resolution dated January 12, 2006 in CA-G.R. CV No. 56400.

SO ORDERED.

ARTURO D. BRION
Associate Justice

WE CONCUR:

ANTONIO T. CARPIO
Associate Justice
Chairperson

MARTIN S. VILLARAMA, JR.
Associate Justice

JOSE CATRAL MENDOZA
Associate Justice

MARVIC M.V.F. LEONEN
Associate Justice

ATTESTATION

I attest that the conclusions in the above Decision had been reached in consultation before the case was assigned to the writer of the opinion of the Court's Division.

ANTONIO T. CARPIO
Associate Justice
Chairperson, Second Division

CERTIFICATION

Pursuant to Section 13, Article VIII of the Constitution, and the Division Chairperson's Attestation, I certify that the conclusions in the above Decision had been reached in consultation before the case was assigned to the writer of the opinion of the Court's Division.

MARIA LOURDES P. A. SERENO
Chief Justice