

DR. RUBI LI, PETITIONER, VS. SPOUSES REYNALDO AND LINA SOLIMAN, AS PARENTS/HEIRS OF DECEASED ANGELICA SOLIMAN, RESPONDENTS.

G.R. No. 165279. June 07, 2011

Ponente: VILLARAMA, JR., J.

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VILLARAMA, JR., J.:

Challenged in this petition for review on certiorari is the Decision[1] dated June 15, 2004 as well as the Resolution[2] dated September 1, 2004 of the Court of Appeals (CA) in CA-G.R. CV No. 58013 which modified the Decision[3] dated September 5, 1997 of the Regional Trial Court of Legazpi City, Branch 8 in Civil Case No. 8904.

The factual antecedents:

On July 7, 1993, respondents' 11-year old daughter, Angelica Soliman, underwent a biopsy of the mass located in her lower extremity at the St. Luke's Medical Center (SLMC). Results showed that Angelica was suffering from osteosarcoma, osteoblastic type,[4] a high-grade (highly malignant) cancer of the bone which usually afflicts teenage children. Following this diagnosis and as primary intervention, Angelica's right leg was amputated by Dr. Jaime Tamayo in order to remove the tumor. As adjuvant treatment to eliminate any remaining cancer cells, and hence minimize the chances of recurrence and prevent the disease from spreading to other parts of the patient's body (metastasis), chemotherapy was suggested by Dr. Tamayo. Dr. Tamayo referred Angelica to another doctor at SLMC, herein petitioner Dr. Rubi Li, a medical oncologist.

On August 18, 1993, Angelica was admitted to SLMC. However, she died on September 1, 1993, just eleven (11) days after the (intravenous) administration of the first cycle of the chemotherapy regimen. Because SLMC refused to release a death certificate without full payment of their hospital bill, respondents brought the cadaver of Angelica to the Philippine National Police (PNP) Crime Laboratory at Camp Crame for post-mortem examination. The Medico-Legal Report issued by said institution indicated the cause of death as "Hypovolemic shock secondary to multiple organ hemorrhages and Disseminated Intravascular Coagulation." [5]

On the other hand, the Certificate of Death[6] issued by SLMC stated the cause of death as follows:

Immediate cause : a. Osteosarcoma, Status Post AKA

Antecedent cause : b. (above knee amputation)

Underlying cause : c. Status Post Chemotherapy

On February 21, 1994, respondents filed a damage suit[7] against petitioner, Dr. Leo Marbella, Mr. Jose Ledesma, a certain Dr. Arriete and SLMC. Respondents charged them with negligence and disregard of Angelica's safety, health and welfare by their careless administration of the chemotherapy drugs, their failure to observe the essential precautions in detecting early the symptoms of fatal blood platelet decrease and stopping early on the chemotherapy, which bleeding led to hypovolemic shock that caused Angelica's untimely demise. Further, it was

specifically averred that petitioner assured the respondents that Angelica would recover in view of 95% chance of healing with chemotherapy ("Magiging normal na ang anak nyo basta ma-chemo. 95% ang healing") and when asked regarding the side effects, petitioner mentioned only slight vomiting, hair loss and weakness ("Magsusuka ng kaunti. Malulugas ang buhok. Manghihina"). Respondents thus claimed that they would not have given their consent to chemotherapy had petitioner not falsely assured them of its side effects.

In her answer,[8] petitioner denied having been negligent in administering the chemotherapy drugs to Angelica and asserted that she had fully explained to respondents how the chemotherapy will affect not only the cancer cells but also the patient's normal body parts, including the lowering of white and red blood cells and platelets. She claimed that what happened to Angelica can be attributed to malignant tumor cells possibly left behind after surgery. Few as they may be, these have the capacity to compete for nutrients such that the body becomes so weak structurally (cachexia) and functionally in the form of lower resistance of the body to combat infection. Such infection becomes uncontrollable and triggers a chain of events (sepsis or septicemia) that may lead to bleeding in the form of Disseminated Intravascular Coagulation (DIC), as what the autopsy report showed in the case of Angelica.

Since the medical records of Angelica were not produced in court, the trial and appellate courts had to rely on testimonial evidence, principally the declarations of petitioner and respondents themselves. The following chronology of events was gathered:

On July 23, 1993, petitioner saw the respondents at the hospital after Angelica's surgery and discussed with them Angelica's condition. Petitioner told respondents that Angelica should be given two to three weeks to recover from the operation before starting chemotherapy. Respondents were apprehensive due to financial constraints as Reynaldo earns only from P70,000.00 to P150,000.00 a year from his jewelry and watch repairing business.[9] Petitioner, however, assured them not to worry about her professional fee and told them to just save up for the medicines to be used.

Petitioner claimed that she explained to respondents that even when a tumor is removed, there are still small lesions undetectable to the naked eye, and that adjuvant chemotherapy is needed to clean out the small lesions in order to lessen the chance of the cancer to recur. She did not give the respondents any assurance that chemotherapy will cure Angelica's cancer. During these consultations with respondents, she explained the following side effects of chemotherapy treatment to respondents: (1) falling hair; (2) nausea and vomiting; (3) loss of appetite; (4) low count of white blood cells [WBC], red blood cells [RBC] and platelets; (5) possible sterility due to the effects on Angelica's ovary; (6) damage to the heart and kidneys; and (7) darkening of the skin especially when exposed to sunlight. She actually talked with respondents four times, once at the hospital after the surgery, twice at her clinic and the fourth time when Angelica's mother called her through long distance.[10] This was disputed by respondents who countered that petitioner gave them assurance that there is 95% chance of healing for Angelica if she undergoes chemotherapy and that the only side effects were nausea, vomiting and hair loss.[11] Those were the only side-effects of chemotherapy treatment mentioned by petitioner.[12]

On July 27, 1993, SLMC discharged Angelica, with instruction from petitioner that she be readmitted after two or three weeks for the chemotherapy.

On August 18, 1993, respondents brought Angelica to SLMC for chemotherapy, bringing with them the results of the laboratory tests requested by petitioner: Angelica's chest x-ray, ultrasound of the liver, creatinine and complete liver function tests.[13] Petitioner proceeded with the chemotherapy by first administering hydration fluids to Angelica.[14]

The following day, August 19, petitioner began administering three chemotherapy drugs - Cisplatin,[15]

Doxorubicin[16] and Cosmegen[17] - intravenously. Petitioner was supposedly assisted by her trainees Dr. Leo Marbella[18] and Dr. Grace Arriete.[19] In his testimony, Dr. Marbella denied having any participation in administering the said chemotherapy drugs.[20]

On the second day of chemotherapy, August 20, respondents noticed reddish discoloration on Angelica's face.[21] They asked petitioner about it, but she merely quipped, "Wala yan. Epekto ng gamot." [22] Petitioner recalled noticing the skin rashes on the nose and cheek area of Angelica. At that moment, she entertained the possibility that Angelica also had systemic lupus and consulted Dr. Victoria Abesamis on the matter.[23]

On the third day of chemotherapy, August 21, Angelica had difficulty breathing and was thus provided with oxygen inhalation apparatus. This time, the reddish discoloration on Angelica's face had extended to her neck, but petitioner dismissed it again as merely the effect of medicines.[24] Petitioner testified that she did not see any discoloration on Angelica's face, nor did she notice any difficulty in the child's breathing. She claimed that Angelica merely complained of nausea and was given ice chips.[25]

On August 22, 1993, at around ten o'clock in the morning, upon seeing that their child could not anymore bear the pain, respondents pleaded with petitioner to stop the chemotherapy. Petitioner supposedly replied: "Dapat 15 Cosmegen pa iyan. Okay, let's observe. If pwede na, bigyan uli ng chemo." At this point, respondents asked petitioner's permission to bring their child home. Later in the evening, Angelica passed black stool and reddish urine.[26] Petitioner countered that there was no record of blackening of stools but only an episode of loose bowel movement (LBM). Petitioner also testified that what Angelica complained of was carpo-pedal spasm, not convulsion or epileptic attack, as respondents call it (petitioner described it in the vernacular as "naninigas ang kamay at paa"). She then requested for a serum calcium determination and stopped the chemotherapy. When Angelica was given calcium gluconate, the spasm and numbness subsided.[27]

The following day, August 23, petitioner yielded to respondents' request to take Angelica home. But prior to discharging Angelica, petitioner requested for a repeat serum calcium determination and explained to respondents that the chemotherapy will be temporarily stopped while she observes Angelica's muscle twitching and serum calcium level. Take-home medicines were also prescribed for Angelica, with instructions to respondents that the serum calcium test will have to be repeated after seven days. Petitioner told respondents that she will see Angelica again after two weeks, but respondents can see her anytime if any immediate problem arises.[28]

However, Angelica remained in confinement because while still in the premises of SLMC, her "convulsions" returned and she also had LBM. Angelica was given oxygen and administration of calcium continued.[29]

The next day, August 24, respondents claimed that Angelica still suffered from convulsions. They also noticed that she had a fever and had difficulty breathing.[30] Petitioner insisted it was carpo-pedal spasm, not convulsions. She verified that at around 4:50 that afternoon, Angelica developed difficulty in breathing and had fever. She then requested for an electrocardiogram analysis, and infused calcium gluconate on the patient at a "stat dose." She further ordered that Angelica be given Bactrim,[31] a synthetic antibacterial combination drug,[32] to combat any infection on the child's body.[33]

By August 26, Angelica was bleeding through the mouth. Respondents also saw blood on her anus and urine. When Lina asked petitioner what was happening to her daughter, petitioner replied, "Bagsak ang platelets ng anak mo." Four units of platelet concentrates were then transfused to Angelica. Petitioner prescribed Soluortef. Considering that Angelica's fever was high and her white blood cell count was low, petitioner prescribed Leucomax. About four to eight bags of blood, consisting of packed red blood cells, fresh whole blood, or platelet concentrate, were transfused to Angelica. For two days (August 27 to 28), Angelica continued bleeding, but petitioner claimed it was lesser in amount and in frequency. Petitioner also denied that there were gadgets

attached to Angelica at that time.[34]

On August 29, Angelica developed ulcers in her mouth, which petitioner said were blood clots that should not be removed. Respondents claimed that Angelica passed about half a liter of blood through her anus at around seven o'clock that evening, which petitioner likewise denied.

On August 30, Angelica continued bleeding. She was restless as endotracheal and nasogastric tubes were inserted into her weakened body. An aspiration of the nasogastric tube inserted to Angelica also revealed a bloody content. Angelica was given more platelet concentrate and fresh whole blood, which petitioner claimed improved her condition. Petitioner told Angelica not to remove the endotracheal tube because this may induce further bleeding.[35] She was also transferred to the intensive care unit to avoid infection.

The next day, respondents claimed that Angelica became hysterical, vomited blood and her body turned black. Part of Angelica's skin was also noted to be shredding by just rubbing cotton on it. Angelica was so restless she removed those gadgets attached to her, saying "Ayaw ko na"; there were tears in her eyes and she kept turning her head. Observing her daughter to be at the point of death, Lina asked for a doctor but the latter could not answer her anymore.[36] At this time, the attending physician was Dr. Marbella who was shaking his head saying that Angelica's platelets were down and respondents should pray for their daughter. Reynaldo claimed that he was introduced to a pediatrician who took over his daughter's case, Dr. Abesamis who also told him to pray for his daughter. Angelica continued to have difficulty in her breathing and blood was being suctioned from her stomach. A nurse was posted inside Angelica's room to assist her breathing and at one point they had to revive Angelica by pumping her chest. Thereafter, Reynaldo claimed that Angelica already experienced difficulty in urinating and her bowel consisted of blood-like fluid. Angelica requested for an electric fan as she was in pain. Hospital staff attempted to take blood samples from Angelica but were unsuccessful because they could not even locate her vein. Angelica asked for a fruit but when it was given to her, she only smelled it. At this time, Reynaldo claimed he could not find either petitioner or Dr. Marbella. That night, Angelica became hysterical and started removing those gadgets attached to her. At three o'clock in the morning of September 1, a priest came and they prayed before Angelica expired. Petitioner finally came back and supposedly told respondents that there was "malfunction" or bogged-down machine.[37]

By petitioner's own account, Angelica was merely irritable that day (August 31). Petitioner noted though that Angelica's skin was indeed sloughing off.[38] She stressed that at 9:30 in the evening, Angelica pulled out her endotracheal tube.[39] On September 1, exactly two weeks after being admitted at SLMC for chemotherapy, Angelica died.[40] The cause of death, according to petitioner, was septicemia, or overwhelming infection, which caused Angelica's other organs to fail.[41] Petitioner attributed this to the patient's poor defense mechanism brought about by the cancer itself.[42]

While he was seeking the release of Angelica's cadaver from SLMC, Reynaldo claimed that petitioner acted arrogantly and called him names. He was asked to sign a promissory note as he did not have cash to pay the hospital bill.[43]

Respondents also presented as witnesses Dr. Jesusa Nieves-Vergara, Medico-Legal Officer of the PNP-Crime Laboratory who conducted the autopsy on Angelica's cadaver, and Dr. Melinda Vergara Balmaceda who is a Medical Specialist employed at the Department of Health (DOH) Operations and Management Services.

Testifying on the findings stated in her medico-legal report, Dr. Vergara noted the following: (1) there were fluids recovered from the abdominal cavity, which is not normal, and was due to hemorrhagic shock secondary to bleeding; (2) there was hemorrhage at the left side of the heart; (3) bleeding at the upper portion of and areas adjacent to, the esophagus; (4) lungs were heavy with bleeding at the back and lower portion, due to accumulation

of fluids; (4) yellowish discoloration of the liver; (5) kidneys showed appearance of facial shock on account of hemorrhages; and (6) reddishness on external surface of the spleen. All these were the end result of "hypovolemic shock secondary to multiple organ hemorrhages and disseminated intravascular coagulation." Dr. Vergara opined that this can be attributed to the chemical agents in the drugs given to the victim, which caused platelet reduction resulting to bleeding sufficient to cause the victim's death. The time lapse for the production of DIC in the case of Angelica (from the time of diagnosis of sarcoma) was too short, considering the survival rate of about 3 years. The witness conceded that the victim will also die of osteosarcoma even with amputation or chemotherapy, but in this case Angelica's death was not caused by osteosarcoma. Dr. Vergara admitted that she is not a pathologist but her statements were based on the opinion of an oncologist whom she had interviewed. This oncologist supposedly said that if the victim already had DIC prior to the chemotherapy, the hospital staff could have detected it.[44]

On her part, Dr. Balmaceda declared that it is the physician's duty to inform and explain to the patient or his relatives every known side effect of the procedure or therapeutic agents to be administered, before securing the consent of the patient or his relatives to such procedure or therapy. The physician thus bases his assurance to the patient on his personal assessment of the patient's condition and his knowledge of the general effects of the agents or procedure that will be allowed on the patient. Dr. Balmaceda stressed that the patient or relatives must be informed of all known side effects based on studies and observations, even if such will aggravate the patient's condition.[45]

Dr. Jaime Tamayo, the orthopaedic surgeon who operated on Angelica's lower extremity, testified for the defendants. He explained that in case of malignant tumors, there is no guarantee that the ablation or removal of the amputated part will completely cure the cancer. Thus, surgery is not enough. The mortality rate of osteosarcoma at the time of modern chemotherapy and early diagnosis still remains at 80% to 90%. Usually, deaths occur from metastasis, or spread of the cancer to other vital organs like the liver, causing systemic complications. The modes of therapy available are the removal of the primary source of the cancerous growth and then the residual cancer cells or metastasis should be treated with chemotherapy. Dr. Tamayo further explained that patients with osteosarcoma have poor defense mechanism due to the cancer cells in the blood stream. In the case of Angelica, he had previously explained to her parents that after the surgical procedure, chemotherapy is imperative so that metastasis of these cancer cells will hopefully be addressed. He referred the patient to petitioner because he felt that petitioner is a competent oncologist. Considering that this type of cancer is very aggressive and will metastasize early, it will cause the demise of the patient should there be no early intervention (in this case, the patient developed sepsis which caused her death). Cancer cells in the blood cannot be seen by the naked eye nor detected through bone scan. On cross-examination, Dr. Tamayo stated that of the more than 50 child patients who had osteogenic sarcoma he had handled, he thought that probably all of them died within six months from amputation because he did not see them anymore after follow-up; it is either they died or had seen another doctor.[46]

In dismissing the complaint, the trial court held that petitioner was not liable for damages as she observed the best known procedures and employed her highest skill and knowledge in the administration of chemotherapy drugs on Angelica but despite all efforts said patient died. It cited the testimony of Dr. Tamayo who testified that he considered petitioner one of the most proficient in the treatment of cancer and that the patient in this case was afflicted with a very aggressive type of cancer necessitating chemotherapy as adjuvant treatment. Using the standard of negligence laid down in *Picart v. Smith*,^[47] the trial court declared that petitioner has taken the necessary precaution against the adverse effect of chemotherapy on the patient, adding that a wrong decision is not by itself negligence. Respondents were ordered to pay their unpaid hospital bill in the amount of P139,064.43.[48]

Respondents appealed to the CA which, while concurring with the trial court's finding that there was no negligence committed by the petitioner in the administration of chemotherapy treatment to Angelica, found that petitioner as her attending physician failed to fully explain to the respondents all the known side effects of chemotherapy. The appellate court stressed that since the respondents have been told of only three side effects of chemotherapy, they readily consented thereto. Had petitioner made known to respondents those other side effects which gravely affected their child -- such as carpo-pedal spasm, sepsis, decrease in the blood platelet count, bleeding, infections and eventual death -- respondents could have decided differently or adopted a different course of action which could have delayed or prevented the early death of their child.

The CA thus declared:

Plaintiffs-appellants' child was suffering from a malignant disease. The attending physician recommended that she undergo chemotherapy treatment after surgery in order to increase her chances of survival. Appellants consented to the chemotherapy treatment because they believed in Dr. Rubi Li's representation that the deceased would have a strong chance of survival after chemotherapy and also because of the representation of appellee Dr. Rubi Li that there were only three possible side-effects of the treatment. However, all sorts of painful side-effects resulted from the treatment including the premature death of Angelica. The appellants were clearly and totally unaware of these other side-effects which manifested only during the chemotherapy treatment. This was shown by the fact that every time a problem would take place regarding Angelica's condition (like an unexpected side-effect manifesting itself), they would immediately seek explanation from Dr. Rubi Li. Surely, those unexpected side-effects culminating in the loss of a love[d] one caused the appellants so much trouble, pain and suffering.

On this point therefore, [w]e find defendant-appellee Dr. Rubi Li negligent which would entitle plaintiffs-appellants to their claim for damages.

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WHEREFORE, the instant appeal is hereby GRANTED. Accordingly, the assailed decision is hereby modified to the extent that defendant-appellee Dr. Rubi Li is ordered to pay the plaintiffs-appellants the following amounts:

- Actual damages of P139,064.43, plus P9,828.00 for funeral expenses;
- Moral damages of P200,000.00;
- Exemplary damages of P50,000.00;
- Attorney's fee of P30,000.00.

SO ORDERED.[49] (Emphasis supplied.)

Petitioner filed a motion for partial reconsideration which the appellate court denied.

Hence, this petition.

Petitioner assails the CA in finding her guilty of negligence in not explaining to the respondents all the possible side effects of the chemotherapy on their child, and in holding her liable for actual, moral and exemplary damages and attorney's fees. Petitioner emphasized that she was not negligent in the pre-chemotherapy procedures and in the administration of chemotherapy treatment to Angelica.

On her supposed non-disclosure of all possible side effects of chemotherapy, including death, petitioner argues that it was foolhardy to imagine her to be all-knowing/omnipotent. While the theoretical side effects of chemotherapy were explained by her to the respondents, as these should be known to a competent doctor,

petitioner cannot possibly predict how a particular patient's genetic make-up, state of mind, general health and body constitution would respond to the treatment. These are obviously dependent on too many known, unknown and immeasurable variables, thus requiring that Angelica be, as she was, constantly and closely monitored during the treatment. Petitioner asserts that she did everything within her professional competence to attend to the medical needs of Angelica.

Citing numerous trainings, distinctions and achievements in her field and her current position as co-director for clinical affairs of the Medical Oncology, Department of Medicine of SLMC, petitioner contends that in the absence of any clear showing or proof, she cannot be charged with negligence in not informing the respondents all the side effects of chemotherapy or in the pre-treatment procedures done on Angelica.

As to the cause of death, petitioner insists that Angelica did not die of platelet depletion but of sepsis which is a complication of the cancer itself. Sepsis itself leads to bleeding and death. She explains that the response rate to chemotherapy of patients with osteosarcoma is high, so much so that survival rate is favorable to the patient. Petitioner then points to some probable consequences if Angelica had not undergone chemotherapy. Thus, without chemotherapy, other medicines and supportive treatment, the patient might have died the next day because of massive infection, or the cancer cells might have spread to the brain and brought the patient into a coma, or into the lungs that the patient could have been hooked to a respirator, or into her kidneys that she would have to undergo dialysis. Indeed, respondents could have spent as much because of these complications. The patient would have been deprived of the chance to survive the ailment, of any hope for life and her "quality of life" surely compromised. Since she had not been shown to be at fault, petitioner maintains that the CA erred in holding her liable for the damages suffered by the respondents.[50]

The issue to be resolved is whether the petitioner can be held liable for failure to fully disclose serious side effects to the parents of the child patient who died while undergoing chemotherapy, despite the absence of finding that petitioner was negligent in administering the said treatment.

The petition is meritorious.

The type of lawsuit which has been called medical malpractice or, more appropriately, medical negligence, is that type of claim which a victim has available to him or her to redress a wrong committed by a medical professional which has caused bodily harm. In order to successfully pursue such a claim, a patient must prove that a health care provider, in most cases a physician, either failed to do something which a reasonably prudent health care provider would have done, or that he or she did something that a reasonably prudent provider would not have done; and that that failure or action caused injury to the patient.[51]

This Court has recognized that medical negligence cases are best proved by opinions of expert witnesses belonging in the same general neighborhood and in the same general line of practice as defendant physician or surgeon. The deference of courts to the expert opinion of qualified physicians stems from the former's realization that the latter possess unusual technical skills which laymen in most instances are incapable of intelligently evaluating, hence the indispensability of expert testimonies.[52]

In this case, both the trial and appellate courts concurred in finding that the alleged negligence of petitioner in the administration of chemotherapy drugs to respondents' child was not proven considering that Drs. Vergara and Balmaceda, not being oncologists or cancer specialists, were not qualified to give expert opinion as to whether petitioner's lack of skill, knowledge and professional competence in failing to observe the standard of care in her line of practice was the proximate cause of the patient's death. Furthermore, respondents' case was not at all helped by the non-production of medical records by the hospital (only the biopsy result and medical bills were submitted to the court). Nevertheless, the CA found petitioner liable for her failure to inform the respondents on

all possible side effects of chemotherapy before securing their consent to the said treatment.

The doctrine of informed consent within the context of physician-patient relationships goes far back into English common law. As early as 1767, doctors were charged with the tort of "battery" (i.e., an unauthorized physical contact with a patient) if they had not gained the consent of their patients prior to performing a surgery or procedure. In the United States, the seminal case was *Schoendorff v. Society of New York Hospital*[53] which involved unwanted treatment performed by a doctor. Justice Benjamin Cardozo's oft-quoted opinion upheld the basic right of a patient to give consent to any medical procedure or treatment: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." [54] From a purely ethical norm, informed consent evolved into a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient as to whatever grave risks of injury might be incurred from a proposed course of treatment, so that a patient, exercising ordinary care for his own welfare, and faced with a choice of undergoing the proposed treatment, or alternative treatment, or none at all, may intelligently exercise his judgment by reasonably balancing the probable risks against the probable benefits.[55]

Subsequently, in *Canterbury v. Spence*[56] the court observed that the duty to disclose should not be limited to medical usage as to arrogate the decision on revelation to the physician alone. Thus, respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.[57] The scope of disclosure is premised on the fact that patients ordinarily are persons unlearned in the medical sciences. Proficiency in diagnosis and therapy is not the full measure of a physician's responsibility. It is also his duty to warn of the dangers lurking in the proposed treatment and to impart information which the patient has every right to expect. Indeed, the patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with armslength transactions.[58] The physician is not expected to give the patient a short medical education, the disclosure rule only requires of him a reasonable explanation, which means generally informing the patient in nontechnical terms as to what is at stake; the therapy alternatives open to him, the goals expectably to be achieved, and the risks that may ensue from particular treatment or no treatment.[59] As to the issue of demonstrating what risks are considered material necessitating disclosure, it was held that experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision. Such unrevealed risk that should have been made known must further materialize, for otherwise the omission, however unpardonable, is without legal consequence. And, as in malpractice actions generally, there must be a causal relationship between the physician's failure to divulge and damage to the patient.[60]

Reiterating the foregoing considerations, *Cobbs v. Grant*[61] deemed it as integral part of physician's overall obligation to patient, the duty of reasonable disclosure of available choices with respect to proposed therapy and of dangers inherently and potentially involved in each. However, the physician is not obliged to discuss relatively minor risks inherent in common procedures when it is common knowledge that such risks inherent in procedure of very low incidence. Cited as exceptions to the rule that the patient should not be denied the opportunity to weigh the risks of surgery or treatment are emergency cases where it is evident he cannot evaluate data, and where the patient is a child or incompetent.[62] The court thus concluded that the patient's right of self-decision can only be effectively exercised if the patient possesses adequate information to enable him in making an intelligent choice. The scope of the physician's communications to the patient, then must be measured by the patient's need, and that need is whatever information is material to the decision. The test therefore for determining whether a potential peril must be divulged is its materiality to the patient's decision.[63]

Cobbs v. Grant further reiterated the pronouncement in Canterbury v. Spence that for liability of the physician for failure to inform patient, there must be causal relationship between physician's failure to inform and the injury to patient and such connection arises only if it is established that, had revelation been made, consent to treatment would not have been given.

There are four essential elements a plaintiff must prove in a malpractice action based upon the doctrine of informed consent: "(1) the physician had a duty to disclose material risks; (2) he failed to disclose or inadequately disclosed those risks; (3) as a direct and proximate result of the failure to disclose, the patient consented to treatment she otherwise would not have consented to; and (4) plaintiff was injured by the proposed treatment." The gravamen in an informed consent case requires the plaintiff to "point to significant undisclosed information relating to the treatment which would have altered her decision to undergo it.[64]

Examining the evidence on record, we hold that there was adequate disclosure of material risks inherent in the chemotherapy procedure performed with the consent of Angelica's parents. Respondents could not have been unaware in the course of initial treatment and amputation of Angelica's lower extremity, that her immune system was already weak on account of the malignant tumor in her knee. When petitioner informed the respondents beforehand of the side effects of chemotherapy which includes lowered counts of white and red blood cells, decrease in blood platelets, possible kidney or heart damage and skin darkening, there is reasonable expectation on the part of the doctor that the respondents understood very well that the severity of these side effects will not be the same for all patients undergoing the procedure. In other words, by the nature of the disease itself, each patient's reaction to the chemical agents even with pre-treatment laboratory tests cannot be precisely determined by the physician. That death can possibly result from complications of the treatment or the underlying cancer itself, immediately or sometime after the administration of chemotherapy drugs, is a risk that cannot be ruled out, as with most other major medical procedures, but such conclusion can be reasonably drawn from the general side effects of chemotherapy already disclosed.

As a physician, petitioner can reasonably expect the respondents to have considered the variables in the recommended treatment for their daughter afflicted with a life-threatening illness. On the other hand, it is difficult to give credence to respondents' claim that petitioner told them of 95% chance of recovery for their daughter, as it was unlikely for doctors like petitioner who were dealing with grave conditions such as cancer to have falsely assured patients of chemotherapy's success rate. Besides, informed consent laws in other countries generally require only a reasonable explanation of potential harms, so specific disclosures such as statistical data, may not be legally necessary.[65]

The element of ethical duty to disclose material risks in the proposed medical treatment cannot thus be reduced to one simplistic formula applicable in all instances. Further, in a medical malpractice action based on lack of informed consent, "the plaintiff must prove both the duty and the breach of that duty through expert testimony.[66] Such expert testimony must show the customary standard of care of physicians in the same practice as that of the defendant doctor.[67]

In this case, the testimony of Dr. Balmaceda who is not an oncologist but a Medical Specialist of the DOH's Operational and Management Services charged with receiving complaints against hospitals, does not qualify as expert testimony to establish the standard of care in obtaining consent for chemotherapy treatment. In the absence of expert testimony in this regard, the Court feels hesitant in defining the scope of mandatory disclosure in cases of malpractice based on lack of informed consent, much less set a standard of disclosure that, even in foreign jurisdictions, has been noted to be an evolving one.

As society has grappled with the juxtaposition between personal autonomy and the medical profession's intrinsic impetus to cure, the law defining "adequate" disclosure has undergone a dynamic evolution. A

standard once guided solely by the ruminations of physicians is now dependent on what a reasonable person in the patient's position regards as significant. This change in perspective is especially important as medical breakthroughs move practitioners to the cutting edge of technology, ever encountering new and heretofore unimagined treatments for currently incurable diseases or ailments. An adaptable standard is needed to account for this constant progression. Reasonableness analyses permeate our legal system for the very reason that they are determined by social norms, expanding and contracting with the ebb and flow of societal evolution.

As we progress toward the twenty-first century, we now realize that the legal standard of disclosure is not subject to construction as a categorical imperative. Whatever formulae or processes we adopt are only useful as a foundational starting point; the particular quality or quantity of disclosure will remain inextricably bound by the facts of each case. Nevertheless, juries that ultimately determine whether a physician properly informed a patient are inevitably guided by what they perceive as the common expectation of the medical consumer--"a reasonable person in the patient's position when deciding to accept or reject a recommended medical procedure." [68] (Emphasis supplied.)

WHEREFORE, the petition for review on certiorari is GRANTED. The Decision dated June 15, 2004 and the Resolution dated September 1, 2004 of the Court of Appeals in CA-G.R. CV No. 58013 are SET ASIDE.

The Decision dated September 5, 1997 of the Regional Trial Court of Legazpi City, Branch 8, in Civil Case No. 8904 is REINSTATED and UPHELD.

No costs.

SO ORDERED.

Corona, C.J., and Perez, JJ., concur.

Carpio, J., see dissenting opinion.

Carpio Morales, Velasco, Jr., and Peralta, JJ., joins the dissent of J., Carpio

Nachura, Leonardo-De Castro, and Mendoza, JJ., I join J. Brion's Separate opinion.

Brion, J. in the result: see separate opinion.

Bersamin, J., concur in the result, and I join the separate opinion of J. Brion.

Del Castillo, J., no part. Abad, J., please see my concurring opinion.

Sereno, J., I dissent. evidence was provided by the doctor- petition herself. I join J. Carpio.

[*] No part.

[1] Rollo, pp. 33-63. Penned by Associate Justice Mariano C. Del Castillo (now a Member of this Court) and concurred in by Associate Justices Roberto A. Barrios and Magdangal M. De Leon.

[2] Id. at 65.

[3] Id. at 119-162. Penned by Judge Salvador D. Silerio.

[4] Records, p. 174.

[5] Id. at 175.

[6] Id. at 254.

[7] Rollo, pp. 80-89.

[8] Id. at 95-108.

[9] TSN, January 26, 1995, p. 3.

[10] TSN, October 6, 1995, pp. 18-26, 60; TSN, January 27, 1997, pp. 4-5.

[11] Rollo, p. 35.

[12] Id. at 35 and 81.

[13] TSN, October 6, 1995, pp. 39-40; rollo, p. 123.

[14] Id. at 40.

[15] Cisplatin is in a class of drugs known as platinum-containing compounds. It slows or stops the growth of cancer cells inside the body. Source: <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a684036.html>. (Site visited on August 21, 2010.)

[16] Doxorubicin is an anti-cancer (antineoplastic or cytotoxic) chemotherapy drug. It is classified as an "anthracycline antibiotic." Source: <http://www.chemocare.com/bio/doxorubicin.asp> (Site visited on August 21, 2010.)

[17] Cosmegen is the trade name for Dactinomycin, an anti-cancer (antineoplastic or cytotoxic) chemotherapy drug classified as an "alkylating agent." Source: <http://www.chemocare.com/bio/cosmegen.asp> (Site visited on August 21, 2010.)

[18] TSN, January 27, 1997, p. 9.

[19] Rollo, p. 124.

[20] TSN, April 22, 1996, pp. 11-12.

[21] Rollo, p. 35.

[22] Id. at 120.

[23] TSN, October 6, 1995, pp. 27-28.

[24] TSN, September 19, 1994, p. 18.

[25] Par. 11 of Answer, rollo, p. 100.

[26] TSN, September 19, 1994, p. 19; paragraph 16 of Complaint, rollo, p. 82.

[27] TSN, October 6, 1995, pp. 28-30; paragraphs 12, 13 & 14 of Answer, rollo, pp. 100-101.

[28] Rollo, p. 101.

[29] TSN, September 19, 1994, p. 22.

[30] Rollo, p. 36.

[31] Id. at 125-126.

[32] <http://www.rxlist.com/bactrim-drug.htm> (Site visited September 2, 2010.)

[33] Paragraph 14 of Answer, rollo, pp. 101-102.

[34] Paragraphs 19-20 of Complaint, rollo, pp. 83; paragraphs 15-17 of Answer, pp. 102-103.

[35] Paragraph 17 of Answer, rollo, p. 103.

- [36] Paragraph 23 of Complaint, rollo, p. 83; TSN, September 19, 1994, pp. 24-25.
- [37] TSN, December 15, 1994, pp. 13-21.
- [38] Paragraph 17 of Answer, rollo, p. 103.
- [39] Id.
- [40] Rollo, p. 37.
- [41] TSN, October 6, 1995, p. 33.
- [42] Id.
- [43] TSN, December 15, 1994, p. 22.
- [44] TSN, December 14, 1994, pp. 15-38.
- [45] TSN, April 28, 1995, pp. 23-25.
- [46] TSN, May 26, 1996, pp. 5, 8-13, 23.
- [47] 37 Phil. 809 (1918).
- [48] Rollo, pp. 160-162.
- [49] Id. at 58-59, 62-63.
- [50] Id. at 18-23.
- [51] Garcia-Rueda v. Pascasio, G.R. No. 118141, September 5, 1997, 278 SCRA 769, 778.
- [52] Lucas v. Tuaño, G.R. No. 178763, April 21, 2009, 586 SCRA 173, 201-202, citing Dr. Cruz v. Court of Appeals, 346 Phil. 872, 884-885 (1997).
- [53] 105 N.E. 92, 93 (N.Y. 1914).**
- [54] Id.
- [55] Black's Law Dictionary, Fifth Edition, p. 701, citing Ze Barth v. Swedish Hospital Medical Center, 81 Wash.2d 12, 499 P.2d 1, 8.
- [56] 464 F.2d 772 C.A.D.C., 1972.
- [57] Id. at 784.
- [58] Id. at 780-782.
- [59] Id. at 782.
- [60] Id. at 790, 791-792.
- [61] 8 Cal.3d 229, 502 P.2d 1 Cal. 1972.
- [62] Id.
- [63] Id.
- [64] Davis v. Kraff, N.E.2d 2010 WL 4026765 III.App. 1 Dist., 2010, citing Coryell v. Smith, 274 III.App.3d 543,

210 Ill.Dec. 855, 653 N.E.2d 1317 (1995).

[65] *Arato v. Avedon*, 858 P.2d 598 (Cal. 1993).

[66] *Mason v. Walsh*, 26 Conn.App. 225, 229-30, 00 A.2d 326 (1991).

[67] *Id.*, 230, citing *Shenefield v. Greenwich Hospital Assn.*, 10 Conn.App. 239, 248-49, 522 A.2d 829 (1987).

[68] "Informed Consent: From the Ambivalence of *Arato* to the Thunder of *Thor*" *Issues in Law & Medicine*, Winter, 1994 by Armand Arabian. Sourced at Internet - http://findarticles.com/p/articles/mi_m6875/is_n3_10/ai_n25022732/pg_37/?tag=content;col1

DISSENTING OPINION

CARPIO, J.:

Dr. Rubi Li (Dr. Li), as oncologist, should have obtained the informed consent of Reynaldo Soliman (Reynaldo) and Lina Soliman (Lina) before administering chemotherapy to their 11-year old daughter Angelica Soliman (Angelica). Unfortunately, Dr. Li failed to do so. For her failure to obtain the informed consent of Reynaldo and Lina, Dr. Li is liable for damages.

The doctrine of informed consent requires doctors, before administering treatment to their patients, to disclose adequately the material risks and side effects of the proposed treatment. The duty to obtain the patient's informed consent is distinct from the doctor's duty to skillfully diagnose and treat the patient. In *Wilkinson v. Vesey*[1], the Supreme Court of Rhode Island held that:

One-half century ago, Justice Cardozo, in the oft-cited case of *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914), made the following observation:

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained." *Id.* at 129-130, 105 N.E. at 93.

x x x x

Shortly after the *Schloendorff* case, there began to appear on the judicial scene a doctrine wherein courts with increasing frequency began to rule that a patient's consent to a proposed course of treatment was valid only to the extent he had been informed by the physician as to what was to be done, the risk involved and the alternatives to the contemplated treatment. This theory, which today is known as the doctrine of informed consent, imposes a duty upon a doctor which is completely separate and distinct from his responsibility to skillfully diagnose and treat the patient's ills. (Emphasis supplied)

Four requisites must be proven in cases involving the doctrine of informed consent. The plaintiff must show that (1) the doctor had a duty to disclose the associated risks and side effects of a proposed treatment; (2) the doctor failed to disclose or inadequately disclosed the associated risks and side effects of the proposed treatment; (3) the plaintiff consented to the proposed treatment because of the doctor's failure to disclose or because of the inadequate disclosure of the associated risks and side effects of the proposed treatment; and (4) the plaintiff was injured as a result of the treatment. In *Coryell v. Smith*,[2] the Court of Appeals of Illinois held that:

To succeed in a malpractice action based on the doctrine of informed consent the plaintiff must plead and ultimately prove four essential elements: (1) the physician had a duty to disclose material risks; (2) he failed to

disclose or inadequately disclosed those risks; (3) as direct and proximate result of the failure to disclose, the patient consented to treatment she otherwise would not have consented to; and (4) plaintiff was injured by proposed treatment.

There are two standards by which courts determine what constitutes adequate disclosure of associated risks and side effects of a proposed treatment: the physician standard, and the patient standard of materiality. Under the physician standard, a doctor is obligated to disclose that information which a reasonable doctor in the same field of expertise would have disclosed to his or her patient. In *Shabinaw v. Brown*,^[3] the Supreme Court of Idaho held that:

A valid consent must be preceded by the physician disclosing those pertinent facts to the patient so that he or she is sufficiently aware of the need for, and the significant risks ordinarily involved in the treatment to be provided in order that the giving or withholding of consent be a reasonably informed decision. The requisite pertinent facts to be disclosed to the patient are those which would be given by a like physician of good standing in the same community. (Emphasis supplied)

Under the patient standard of materiality, a doctor is obligated to disclose that information which a reasonable patient would deem material in deciding whether to proceed with a proposed treatment. In *Johnson by Adler v. Kokemoor*,^[4] the Supreme Court of Wisconsin held that:

x x x The concept of informed consent is based on the tenet that in order to make a rational and informed decision about undertaking a particular treatment or undergoing a particular surgical procedure, a patient has the right to know about significant potential risks involved in the proposed treatment or surgery. In order to insure that a patient can give an informed consent, a "physician or surgeon is under the duty to provide the patient with such information as may be necessary under the circumstances then existing" to assess the significant potential risks which the patient confronts.

The information that must be disclosed is that information which would be "material" to a patient's decision. (Emphasis supplied)

Historically, courts used the physician standard. However, the modern and prevailing trend among courts is to use the patient standard of materiality. In *Johnson by Adler*,^[5] the Court of Appeals of District of Columbia held that:

x x x Some have measured the disclosure by "good medical practice," others by what a reasonable practitioner would have bared under the circumstances, and still others by what medical custom in the community would demand. We have explored this rather considerable body of law but are unprepared to follow it. The duty to disclose, we have reasoned, arises from phenomena apart from medical custom and practice. The latter, we think, should no more establish the scope of the duty than its existence. Any definition of scope in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself. That prerogative, we have said, is at the very foundation of the duty to disclose, and both the patient's right to know and the physician's correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.

In our view, the patient's right to self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. (Emphasis supplied)

In *Johnson by Adler*, the Court held that:

What constitutes informed consent in a given case emanates from what a reasonable person in the patient's

position would want to know. This standard regarding what a physician must disclose is described as the prudent patient standard; it has been embraced by a growing number of jurisdictions since the Canterbury decision.

The Scaria [v. St. Paul Fire & Marine Insurance Co.] court emphasized that those "disclosures which would be made by doctors of good standing, under the same or similar circumstances, are certainly relevant and material" in assessing what constitutes adequate disclosure, adding that physician disclosures conforming to such a standard "would be adequate to fulfill the doctor's duty of disclosure in most instances." But the evidentiary value of what physicians of good standing consider adequate disclosure is not dispositive, for ultimately "the extent of the physician's disclosures is driven... by what a reasonable person under the circumstances then existing would want to know." (Emphasis supplied)

In order to determine what the associated risks and side effects of a proposed treatment are, testimony by an expert witness is necessary because these are beyond the common knowledge of ordinary people. In Canterbury, the Court held that, "There are obviously important roles for medical testimony in [nondisclosure] cases, and some roles which only medical evidence can fill. Experts are ordinarily indispensable to identify and elucidate for the fact-finder the risks of therapy." The Court also held that, "medical facts are for medical experts."

On the other hand, in order to determine what risks and side effects of a proposed treatment are material and, thus, should be disclosed to the patient, testimony by an expert witness is unnecessary. In Canterbury, the Court held that:

x x x It is evident that many of the issues typically involved in nondisclosure cases do not reside peculiarly within the medical domain. Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment. Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision. (Emphasis supplied)

In *Betterton v. Leichtling*,^[6] the Court of Appeals of California held that, "Whether to disclose a significant risk is not a matter reserved for expert opinion."

Again, under the patient standard of materiality, a doctor is obligated to disclose that information which a reasonable patient would deem material in deciding whether to proceed with a proposed treatment. Stated differently, what should be disclosed depends on what a reasonable person, in the same or similar situation as the patient, would deem material in deciding whether to proceed with the proposed treatment.

The testimony of an expert witness is necessary to determine the associated risks and side effects of the treatment. This is the only purpose. In the present case, an expert witness identified the associated risks and side effects of chemotherapy -- Dr. Li is an expert in oncology. In its 5 September 1997 Decision, the Regional Trial Court (RTC), Judicial Region 5, Branch 8, Legazpi City, stated that:

Dr. Rubi Li is a Doctor of Medicine and a Medical Oncologist. She obtained her degree in Medicine in 1981 at the University of the East. She went on Junior Internship for one year in Rizal Medical Center wherein she was exposed to different diseases and specifications. After the post-graduate internship she underwent six (6) months rural service internship and then took and passed the board examination. She likewise underwent a 3-year residency training in internal medicine wherein she was exposed to different patients, particularly patients with bone diseases and cancer patients, including their treatment. After the residency training in internal medicine, one becomes an internist. She likewise underwent sub-specialty training in medical oncology wherein she dealt with cancer patients, including bone and breast cancers, and learned how to deal with the patient as a whole and the treatment. Before she was admitted to the Society of Medical Oncologists, she first took the test for and registered with the Philippine College of Physicians. She was likewise invited to join the Society of Clinical Oncologists. She has written and has been co-authoring papers on cancer and now

she is into the training program of younger doctors and help them with their papers.

Every year Dr. Li goes to conventions, usually in May, known as the American Society of Clinical Oncologist Convention, wherein all the sub-specialties in cancer treatment and management meet and the latest in cancer treatment and management is [sic] presented. In December of each year the Philippine Society of Medical Oncologists have their convention wherein the latest with regards [sic] to what is going on in the Philippines is presented. They also have an upgrading or what they call continuous medical education with [sic] cancer, which is usually every now and then, especially when there are foreign guests from abroad.

Dr. Li has been dealing with bone cancer treatment for almost thirteen (13) years now and has seen more than 5,000 patients.

As an expert, Dr. Li identified the associated risks and side effects of chemotherapy: (1) falling hair; (2) nausea; (3) vomiting; (4) loss of appetite; (5) lowering of white blood cell count; (6) lowering of red blood cell count; (7) lowering of platelet count; (8) sterility; (9) damage to the kidneys; (10) damage to the heart; (11) skin darkening; (12) rashes; (13) difficulty in breathing; (14) fever; (15) excretion of blood in the mouth; (16) excretion of blood in the anus; (17) development of ulcers in the mouth; (18) sloughing off of skin; (19) systemic lupus erythematosus; (20) carpo-pedal spasm; (21) loose bowel movement; (22) infection; (23) gum bleeding; (24) hypovolemic shock; (25) sepsis; and (26) death in 13 days.

Dr. Li admitted that she assured Reynaldo and Lina that there was an 80% chance that Angelica's cancer would be controlled and that she disclosed to them only some of the associated risks and side effects of chemotherapy. In its 5 September 1997 Decision, the RTC stated that:

By way of affirmative and special defenses, Dr. Rubi Li alleged that she saw the deceased patient, Angelica Soliman, and her parents on July 25, 1993, and discussed the patient's condition and the possibility of adjuvant chemotherapy x x x. The giving of chemotherapy is merely in aid, or an adjuvant, of surgery, hoping to prevent or control the recurrence of the malignant disease (cancer). The plaintiffs were likewise told that there is 80% chance that the cancer could be controlled and that no assurance of cure was given, considering that the deceased was suffering from cancer which up to this moment, cure is not yet discovered and not even the exact cause of cancer is known up to the present.

Plaintiffs were likewise informed that chemotherapy will be given through dextrose and will, therefore, affect not only the cancer cells, but also the patient's normal parts of the body, more particularly the fast growing parts, and as a result, the patient was expected to experience, as she has in fact experienced, side effects consisting of: 1) Falling hair; 2) Nausea and vomiting; 3) Loss of appetite considering that there will be changes in the taste buds of the tongue and lead to body weakening; 4) Low count of white blood cells (WBC count), red blood cells (RBC count), and platelets as these would be lowered by the chemotherapy; 5) The deceased patient's ovaries may be affected resulting to sterility; 6) The kidneys and the heart might be affected; and 7) There will be darkening of the skin especially when the skin is exposed to sunlight.

Thus, Dr. Li impliedly admits that she failed to disclose to Reynaldo and Lina many of the other associated risks and side effects of chemotherapy, including the most material -- infection, sepsis and death. She impliedly admits that she failed to disclose as risks and side effects (1) rashes; (2) difficulty in breathing; (3) fever; (4) excretion of blood in the mouth; (5) excretion of blood in the anus; (6) development of ulcers in the mouth; (7) sloughing off of skin; (8) systemic lupus erythematosus; (9) carpo-pedal spasm; (10) loose bowel movement; (11) infection; (12) gum bleeding; (13) hypovolemic shock; (14) sepsis; and (15) death in 13 days.

Clearly, infection, sepsis and death are material risks and side effects of chemotherapy. To any reasonable person, the risk of death is one of the most important, if not the most important, consideration in deciding whether to undergo a proposed treatment. Thus, Dr. Li should have disclosed to Reynaldo and Lina that there was a chance

that their 11-year old daughter could die as a result of chemotherapy as, in fact, she did after only 13 days of treatment.

In *Canterbury* and in *Wilkinson*, the Court of Appeals of District of Columbia and Supreme Court of Rhode Island, respectively, held that, "A very small chance of death x x x may well be significant." In the present case, had Reynaldo and Lina fully known the severity of the risks and side effects of chemotherapy, they may have opted not to go through with the treatment of their daughter. In fact, after some of the side effects of chemotherapy manifested, they asked Dr. Li to stop the treatment.

The facts, as stated by the RTC and the Court of Appeals, clearly show that, because of the chemotherapy, Angelica suffered lowering of white blood cell count, lowering of red blood cell count, lowering of platelet count, skin darkening, rashes, difficulty in breathing, fever, excretion of blood in the mouth, excretion of blood in the anus, development of ulcers in the mouth, sloughing off of skin, systemic lupus erythematosus, carpo-pedal spasm, loose bowel movement, infection, gum bleeding, hypovolemic shock, sepsis, and death after 13 days.

After the administration of chemotherapy, Angelica suffered infection, which progressed to sepsis. Thereafter, Angelica died. In its 5 September 1997 Decision, the RTC stated that:

Angelica Soliman was admitted at the St. Luke's Medical Center on August 18, 1993. Preparatory to the chemotherapy, she was hydrated to make sure that her kidneys will function well and her output was monitored. Blood test, blood count, kidney function test and complete liver function test were likewise done. Chemotherapy started on August 19, 1993 with the administration of the three drugs, namely, Cisplatin, Doxorubicin and Cosmegen. In the evening Angelica started vomiting which, according to Dr. Rubi Li, was just an effect of the drugs administered.

Chemotherapy was likewise administered on August 20, 1993. Vomiting continued. On August 21, 1993 Angelica Soliman developed redness or rashes all over her face, particularly on the nose and cheek area, which on subsequent day became darker and has spread to the neck and chest. Dr. Li told plaintiffs that was just a reaction or effect of the medicines and it was normal. Vomiting likewise continued. Dr. Li then consulted Dr. Abesamis, a pediatric oncologist, because she was entertaining the possibility that the patient might also have systemic lupus erythematosus.

Angelica Soliman developed fever and difficulty of breathing on the fourth day and she became weak already. She was placed on oxygen and antibiotics. Her blood count was checked. Dr. Li began to entertain the possibility of infection, the lungs being considered the focus of such infection. An auscultation of the lungs showed just harsh breathing sounds. She was given Bactrim. The following day the antibiotic was changed into something stronger by giving the patient Fortum intravenously. Dr. Li started to consider the possibility of beginning sepsis, meaning that the germs or bacteria were already in the blood system. Fortum did not, however, take effect. White cells were down and it was not enough to control the infection because there was nothing in her body to fight and help Fortum fight the infection. Another medicine, Leucomax, was added that would increase the patient's white cell count, but even this did not help.

Plaintiffs then requested Dr. Li to stop the chemotherapy. Dr. Li complied, although according to her the chemotherapy should not be stopped. So chemotherapy was not given on August 22, 1993. Plaintiffs then asked if they could already bring their daughter home. They were permitted by Dr. Li.

On August 23, 1993, preparatory to the discharge, Dr. Li prescribed take home medicines, but while still in the premises of SLMC, Angelica Soliman had a convulsive attack so she was placed back to her room.

This convulsive attack mentioned by the plaintiffs was actually what is referred to as "carpopedal spasm" in medical parlance, which Dr. Li described as "naninigas ang kamay at paa." It is a twitching of a group of muscles of the hands and legs. The patient's calcium was checked and it was noted to be low, so she was given

supplemental calcium which calmed her down. ECG was likewise conducted. Angelica Soliman started to bleed through the mouth. This, according to Dr. Li, was only a spitting of blood because at that time the patient had gum bleeding. Dr. Li told plaintiffs the bleeding was due to platelet reduction. Angelica Soliman was then transferred to a private room wherein the plaintiffs themselves were required to wear a mask to avoid any infection as their daughter was already sensitive and they might have colds or flu and might contaminate the patient who was noted to have low defense mechanism to infection. Plaintiffs were asked to sign a consent form for blood transfusion. Patient was transfused with more than three (3) bags of blood and platelets. The bleeding was lessened, but she became weak.

The bleeding and blood transfusion continued until August 31, 1993. Angelica Soliman became hysterical and uneasy with the oxygen and nasogastric tube attached to her. Parts of her skin were shredding or peeling off, and according to plaintiffs, she already passed black stool.

On September 1, 1993, at around 3:00 p.m., Angelica Soliman died, but prior to her demise, she pulled out her endotracheal tube at 9:30 p.m. of August 31, 1993.

As admitted by Dr. Li, infection, sepsis and death are associated risks and side effects of chemotherapy. These risks and side effects are material to Reynaldo and Lina, and to any other reasonable person, in deciding whether to undergo chemotherapy. Had Dr. Li adequately disclosed to Reynaldo and Lina that there was a chance that their 11-year old daughter could die of infection as a result of chemotherapy, they may have decided against it and sought for an alternative treatment.

Accordingly, I vote to DENY the petition.

[1] 110 R.I. 606, 295 A. 2d 676, 69 A.L.R. 3d 1202.

[2] 274 Ill. App. 3d 543, 653 N.E. 2d 1317.

[3] 125 Idaho 705, 874 P. 2d 516.

[4] 199 Wis. 2d 615, 545 N.W. 2d 495.

[5] 464 F. 2d 772, 150 U.S. App. D.C. 263.

[6] 101 Cal. App. 4[Th] 749.

SEPARATE OPINION

BRION, J.:

I. The Concurrence and Supporting Reasons

I concur in the result with the ponencia and its conclusion that the respondents failed to prove by preponderance of evidence the essential elements of a cause of action based on the doctrine of informed consent. This case presents to us for the first time the application of the common-law doctrine of informed consent in a medical negligence case, based on Article 2176 of the Civil Code. I do not question the applicability of this novel doctrine in this jurisdiction.

However, I do not agree with the ponencia's conclusion that "there was adequate disclosure of material risks of the [chemotherapy administered] with the consent of Angelica's parents" [1] in view of a complete absence of competent expert testimony establishing a medical disclosure standard in the present case. As I shall discuss

below, the respondents failed to sufficiently establish the information that should have been disclosed to enable them to arrive at a decision on how proceed with the treatment.

As in any ordinary medical negligence action based on Article 2176 of the Civil Code, the burden to prove the necessary elements - i.e., duty, breach, injury and proximate causation - rests with the plaintiff. [2] In a lack of informed consent litigation, the plaintiff must prove by preponderance of evidence the following requisites: [3]

- (1) the physician had a duty to disclose material risks;
- (2) he failed to disclose or inadequately disclosed those risks;
- (3) as a direct and proximate result of the failure to disclose, the patient consented to treatment she otherwise would not have consented to; and
- (4) plaintiff was injured by the proposed treatment.

Of crucial significance in establishing the elements involved in medical negligence cases is expert medical testimony since the facts and issues to be resolved by the Court in these cases are matters peculiarly within the knowledge of experts in the medical field. [4]

I base my conclusion on the ground that the respondents failed to prove by competent expert testimony the first and fourth elements of a prima facie case for lack of informed consent, specifically:

- (1) the scope of the duty to disclose and the violation of this duty, i.e., the failure to define what should be disclosed and to disclose the required material risks or side effects of the chemotherapy that allow the patient (and/or her parents) to properly decide whether to undergo chemotherapy; and
- (2) that the chemotherapy administered by the petitioner proximately caused the death of Angelica Soliman.

II. Background

On July 7, 1993, the respondents Spouses Reynaldo and Lina Soliman's (respondents) 11-year old daughter, Angelica Soliman (Angelica), was diagnosed with osteosarcoma, osteoblastic type (cancer of the bone) after a biopsy of the mass in her lower extremity showed a malignancy. Following this diagnosis, Dr. Jaime Tamayo (Dr. Tamayo) of the St. Luke's Medical Center (SLMC) amputated Angelica's right leg to remove the tumor. Dr. Tamayo also recommended adjuvant chemotherapy to eliminate any remaining cancer cells and prevent its spread to the other parts of the body, and referred Angelica to the petitioner Dr. Rubi Li (petitioner), an oncologist. [5]

On July 23, 1993, the petitioner saw the respondents and discussed with them Angelica's condition. [6] The petitioner claims that she did not then give the respondents any assurance that chemotherapy would cure Angelica's cancer considering that "a cure for cancer has not been discovered" and "its exact cause is not known up to the present"; she merely told them that there is 80% chance that the cancer [of Angelica] could be controlled [by chemotherapy]. [7] In her Answer, the petitioner alleges that she informed the respondents that chemotherapy will be administered intravenously; the chemotherapy will flow throughout Angelica's body and will affect not only the cancer cells but also the fast growing "normal" parts of her body. She also then disclosed and explained to the respondents the following side effects of chemotherapy:

- (1) Falling hair;
- (2) Nausea and vomiting;
- (3) Loss of appetite considering that there will be changes in the taste buds of the tongue and lead to body weakness and this defendant therefore, in anticipation of the changes in the taste buds, instructed the plaintiffs to teach and encourage the deceased patient to eat even though she has no normal taste;
- (4) Low count of white blood cells (WBC count), red blood cells (RBC count), and platelets as these would be

lowered by the chemotherapy and therefore this defendant had to check these counts before starting the chemotherapy (it is important to note at this point that white blood cells [WBC] are the cells that defend the body against infection);

(5) The deceased patient's ovaries may be affected resulting to sterility;

(6) The kidneys and the heart might be affected so that this defendant had to check the status of these organs before starting chemotherapy;

(7) There will be darkening of the skin especially when the skin is exposed to sunlight. [8]

The respondents, however, disputed this claim and countered that the petitioner gave them an assurance that there was a 95% chance of healing if Angelica would undergo chemotherapy - "Magiging normal na ang anak nyo basta ma-chemo. 95 % ang healing. - and that the side effects were only hair loss, vomiting and weakness - "Magsusuka ng kaunti. Malulugas ang buhok. Manghihina." [9]

On August 18, 1993, Angelica was readmitted to the SLMC for chemotherapy. Upon admission, Angelica's mother, respondent Lina Soliman, signed the Consent for Hospital Care, which pertinently stated: [10]

Permission is hereby given to the medical, nursing and laboratory staff of St. Luke's Medical Center to perform such diagnostic procedures and administer such medications and treatments as may be deemed necessary or advisable by the Physicians of this hospital [for my daughter] during this confinement. It is understood that such procedures may include blood transfusions, intravenous or other injections and infusions[,] administrations of serums, antitoxins and toxoids for treatment or prophylaxis, local of (sic) general anesthesia, spinal puncture, bone marrow puncture, venesection, thoracentesis, paracentesis, physiotherapy and laboratory test.

The following day, the petitioner intravenously administered three chemotherapy drugs, namely: Cisplatin, Doxorubicin and Cosmegen. On September 1, 1993, or thirteen days after the induction of the first cycle of chemotherapy, Angelica died. [11] The autopsy conducted by the Philippine National Police (PNP) Crime Laboratory indicated the cause of death as "Hypovolemic shock secondary to multiple organ hemorrhages and Disseminated Intravascular Coagulation." [12]

On February 21, 1994, the respondents filed a case for damages against the petitioner, Dr. Leo Marbella, a certain Dr. Arriete and SLMC. The respondents raised two causes of action; the first cause of action was based on the petitioner's negligence in the administration of the chemotherapy, and the second cause of action was based on the petitioner's negligence in failing to disclose the risks or side effects of chemotherapy so that they could give a valid informed consent. [13] In her Answer, the petitioner countered that she was not negligent and that the massive bleeding that caused Angelica's death was brought about by her underlying condition and the sepsis that resulted from her weakened immune system. [14]

a. The RTC Ruling

The trial court dismissed the complaint and held that the petitioner was not negligent since she observed the best known procedures and employed her highest skill and knowledge in the administration of the chemotherapy to Angelica. It cited Dr. Tamayo's testimony that he knew the petitioner as one of the most proficient in the treatment of cancer and that Angelica was afflicted with a very aggressive type of cancer that necessitated adjuvant chemotherapy. [15]

b. The CA Ruling

On appeal, the Court of Appeals (CA) - while concurring with the trial court's finding that the petitioner was not negligent in the administration of the chemotherapy to Angelica - found the petitioner negligent in failing to explain fully to the respondents all the known side effects of the chemotherapy. The CA gave credence to the

respondents' testimony that the petitioner merely told them of only three side effects of chemotherapy, which prompted them to readily give their consent. The CA stressed that had the petitioner made known to the respondents the other side effects (carpo-pedal spasm, sepsis, decrease in platelet counts, bleeding, infection and death), which gravely affected Angelica, they could have decided differently or took a different course of action, which could have delayed or prevented the early death of their child. [16]

c. The Respondents' Supporting Testimonies

Angelica's medical records were not submitted in evidence; instead, the Regional Trial Court (RTC) and the CA solely relied on the testimonial evidence of the petitioner and the respondents.

In support of her Complaint, the respondent Lina Soliman testified on direct examination that on August 18, 1993, Angelica was admitted to the SLMC for chemotherapy. She declared that the petitioner examined Angelica on that same day and administered dextrose on her. The petitioner assured them that if Angelica is subjected to chemotherapy, there will be a "95% chance" that "she will be normal" and that the "possible side effects of chemotherapy" are "falling of the hair, vomiting and weakness (manghihina)." [17] On cross examination, the respondent Lina Soliman clarified that "when she insisted on some other possible side effect," the petitioner said that those three she mentioned "were the only [side] effects." [18] During rebuttal, the respondent Lina Soliman testified that the petitioner gave them a "90% guarantee that if [her] daughter will be subjected to chemotherapy, [her] child will recover completely." [19] Finally, she declared that she was only aware of the three side effects and had she known all the side effects of chemotherapy that the petitioner should have mentioned, she would not have subjected Angelica to the chemotherapy. [20]

The respondent Reynaldo Soliman was also presented to corroborate the testimony of his wife Lina Soliman. He declared that he asked the petitioner about the side effects of chemotherapy and that the petitioner mentioned of only "falling hair, weakness and vomiting" to him. [21]

During the trial, the respondents also presented two expert witnesses: Dr. Jesusa Vergara, a Medico-Legal Officer of the PNP Crime Laboratory, and Dr. Melinda Balmaceda, a Medical Specialist employed at the Department of Health (DOH). [22]

Dr. Vergara declared that she has been a physician since 1989; she did not undergo medical resident physician training and only practiced as a general practitioner at Andamon General Hospital in Lucena City for six months. She testified further that she has been employed as a Medico-Legal Officer at the PNP Crime Laboratory since January 1990. In this capacity, she declared that she performs autopsy to determine the cause of death of victims; conducts examinations of rape victims, victims of other sex crimes and physical injuries; examines and identifies skeletal remains; attends court hearings on cases she has examined; and gives lectures to students and medico-legal opinion on cases referred to her. [23]

Dr. Vergara testified that she conducted the autopsy on Angelica's body on September 2, 1993. She explained that the extensive multiple organ hemorrhages and disseminated intravascular coagulation that caused Angelica's demise can be attributed to the chemical agents given to her; these agents caused platelet reduction resulting in massive bleeding and, eventually, in her death. She further noted that Angelica would have also died of osteosarcoma even with amputation and chemotherapy; in this case, her death was not caused by osteosarcoma as it has a survival period of three years. [24] Dr. Vergara admitted that she is not a pathologist; [25] also, her statements were based on the opinion of an oncologist she had previously interviewed. [26]

Dr. Balmaceda, for her part, declared that she is a Medical Specialist working at the DOH Operations and Management Service; her work encompasses the administration and management of medical hospitals; her office

receives complaints against hospitals for mismanagement of admissions and medical health. Dr. Balmaceda also stated that she obtained a Masters of Hospital Administration from the Ateneo de Manila University, and took special courses on medical and pediatric training at the Philippine General Hospital and Children's Medical Center in 1979. [27]

Dr. Balmaceda testified that it is a physician's duty to inform and explain to the patient or his family every known side effect of the therapeutic agents to be administered, before securing their consent. She stressed that the patient or his family must be informed of all known side effects based on studies and observations, even if this disclosure will have the effect of aggravating the patient's condition. [28] On cross-examination, Dr. Balmaceda admitted that she is not an oncologist. [29]

Despite their counsel's representation during the trial, the respondents failed to present expert testimony from an oncologist or a physician who specializes in the diagnosis and treatment of cancers. [30]

d. The Petitioner's Supporting Expert Testimonies

The petitioner testified that she is a licensed physician and a board certified medical oncologist; she underwent sub-specialty training in medical oncology where she dealt with different types of cancers, including bone cancers. She also declared that she is a member of the Philippine Society of Medical Oncologists; has written and co-authored various medical papers on cancer; and has attended yearly conventions of the American Society of Clinical Oncology and the Philippine Society of Medical Oncologists where she was updated with the latest advances in cancer treatment and management. The petitioner also declared that she has been engaged in the treatment and management of bone cancers for almost thirteen years, and has seen more than 5,000 patients. [31]

On direct examination, the petitioner testified that she met and discussed the side effects of chemotherapy with the respondents three times; she mentioned that the side effects of chemotherapy may consist of hair loss, nausea, vomiting, sterility, and low white and red blood cells and platelet count. She declared that the respondents consented to the chemotherapy when they signed the hospital's consent form. [32]

The petitioner also declared that Angelica died not because of the chemotherapy but because of sepsis - an overwhelming infection that caused her organs to fail. She testified that the cancer brought on the sepsis because of her poor defense mechanism. [33] On cross-examination, the petitioner clarified that the sepsis also triggered the platelet reduction; the bleeding was, in fact, controlled by the blood transfusion but the infection was so prevalent it was hard to control. The petitioner also added that the three drugs administered to Angelica could theoretically cause platelet reduction, but a decrease in platelets is usually seen only after three cycles of chemotherapy and not in the initial administration. [34]

Dr. Tamayo, the orthopedic surgeon who amputated Angelica's right leg, testified for the petitioner. He explained that the modes of therapy for Angelica's cancer are the surgical removal of the primary source of the cancerous growth and, subsequently, the treatment of the residual cancer (metastatic) cells with chemotherapy. [35] He further explained that patients with osteosarcoma have a poor defense mechanism due to the cancer cells in the bloodstream. In Angelica's case, he explained to the parents that chemotherapy was imperative to address metastasis of cancerous cells since osteosarcoma is a very aggressive type of cancer requiring equally aggressive treatment. He declared that the mortality rate for osteosarcoma remains at 80% to 90% despite the advent of modern chemotherapy. Finally, Dr. Tamayo testified that he refers most of his cancer patients to the petitioner since he personally knows her to be a very competent oncologist. [36]

III. The Ponencia

The ponencia cites two grounds for granting the petition. First, there was adequate disclosure of the side effects of

chemotherapy on the part of the petitioner. Second, the respondents failed to present expert testimony to establish the standard of care in obtaining consent prior to chemotherapy.

a. Adequate Disclosure of Material Risks

The ponencia finds "that there was adequate disclosure of material risks inherent in the chemotherapy [administered] with the consent of Angelica's parents." The ponencia emphasizes that when the petitioner informed the respondents of the side effects of chemotherapy (i.e. low white and red blood cell and platelet count, kidney or heart damage and skin darkening), it was reasonable for the former to expect that the latter understood very well the side effects are not be the same for all patients undergoing the procedure. Given this scenario, the ponencia notes that the "respondents could not have been unaware in the course of initial treatment... that [Angelica's] immune system was already weak on account of the malignant tumor in her knee." The ponencia also implies that death as a result of complications of the chemotherapy or the underlying cancer is a risk that can be reasonably inferred by the respondents from the general side effects disclosed by the petitioner. Finally, the ponencia disregarded the respondents' claim that the petitioner assured them of 95% chance of recovery for Angelica as it is unlikely for doctors (like the petitioner) who are dealing with grave illnesses to falsely assure patients of the chemotherapy's success rate; at any rate, specific disclosures such as statistical data are not legally necessary. [37]

b. Failure to Present Expert Testimony

The ponencia holds that in a medical malpractice action based on lack of informed consent, the plaintiff must prove both the duty to disclose material risks and the breach of that duty through expert testimony. The expert testimony must show the customary standard of care of physicians in the same practice as that of the defendant doctor. In the present case, the ponencia notes that Dr. Balmaceda's expert testimony is not competent to establish the standard of care in obtaining consent for chemotherapy treatment. [38]

IV. The Doctrine of Informed Consent

The present case is one of first impression in this jurisdiction in the application of the doctrine of informed consent in a medical negligence case. For a deeper appreciation of the application of this novel doctrine, a brief look at the historical context, the different approaches underlying informed consent, and the standards of disclosure would be very helpful.

a. Battery v. Negligence Approaches

The doctrine of informed consent first appeared in American jurisprudence in cases involving unconsented surgeries which fit the analytical framework of traditional battery. [39] Most commentators begin their discussions of the legal doctrine of informed consent with the "famous 1914 opinion of Associate Justice Benjamin Cardozo in *Schloendorff v. Society of New York Hospitals*" [40] where he wrote:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault, for which he is liable in damages. This is true, except in cases of medical emergency, where the patient is unconscious, and where it is necessary to operate before consent can be obtained. [41]

Schloendorff is significant because it "characterized the wrong [committed by the physician] as a trespass, and not [as] a negligent act." It illustrated the concept of medical battery "[where] a patient is subjected to an examination or treatment without express or implied consent." Thus, "[this] battery approach to informed consent seeks to protect the patient's physical integrity and personal dignity from harmful and unwanted contact." [42]

"[A]s the century progressed and the practice of medicine became more sophisticated, courts began to consider whether the patient had been given sufficient information to give true consent." [43] One commentator notes that in the mid-1950s, the courts had shifted their focus from the issue of whether the patient gave consent, to whether adequate information was given for the patient to have made an informed consent. Thus, the quantity of information provided to the patient in making decisions regarding medical treatment was given greater scrutiny and the physician's duty to disclose assumed a primary role. [44]

The 1957 case of *Salgo v. Leland Stanford Jr. University of Board of Trustees* [45] first "established the modern view of the doctrine of informed consent," declaring "that the physician violates his duty to his patient if he fails to provide information necessary for the patient to form intelligent consent to the proposed treatment." [46] Although *Salgo* held that the physician was under a duty to disclose, this duty remained unclear; it did not answer the critical question of "what constituted 'full disclosure' sufficient for the patient to make an informed consent." [47]

In the 1960s, "[c]ourts and commentators began to understand [and realize] that actions for battery - an intentional tort - made little sense when couched in negligence terminology." [48] Thus, in 1960, the Kansas Supreme Court explicitly rejected the battery approach in *Natanson v. Kline* [49] where it held that the "failure to disclose to the patient sufficient information to allow informed consent to the procedure was an action based in negligence and not on an unconsented x x x touching [or] battery." [50] The courts in *Natanson v. Kline* [51] and *Mitchell v. Robinson* [52] clarified as well the scope of the physician's duty to disclose and held that the "central information needed in making an informed consent was a disclosure of the material risks involved in a medical procedure." [53] *Natanson* went on to require the physician to provide "in addition to risk information, disclosure of the ailment, the nature of the proposed treatment, the probability of success, and possible alternative treatments." [54]

Finally, in 1972, the California Supreme Court in *Cobbs v. Grant* [55] articulated "the rationale behind abandoning the battery approach to informed consent in favor of [a] negligence approach." It held that "it was inappropriate to use intentional tort of battery when the actual wrong was an omission, and the physician acted without intent to injure the patient." [56]

b. Standards of Disclosure: Professional Disclosure Standard v. Reasonable Patient Standard

A significant development in the evolution of the doctrine of informed consent in the United States is the standard by which the adequacy of disclosure is judged. [57] In *Natanson*, [58] the Court examined the adequacy of the physician's disclosure by looking at accepted medical practices and held that a charge of failure to disclose should be judged by the standards of the reasonable medical practitioner. This came to be known as the "professional disclosure standard." [59] The question under the standard is: did the doctor disclose the information that, by established medical practice, is required to be disclosed? Under this standard, "a patient claiming a breach of the duty was required to produce expert medical testimony as to what the standard practice would be in [the medical community in a particular case] and how the physician deviated from the practice." [60] This requirement, however, came under harsh criticism as one commentator noted:

The fulfillment of this requirement often precluded a finding of liability not only because of the difficulty in obtaining expert testimony, and breaking through the medical community's so-called "conspiracy of silence," but also because there was no real community standard of disclosure. Establishing community custom through expert testimony is perfectly acceptable where such custom exists. However, because a physician supposedly considers his patient's emotional, mental, and physical condition in deciding whether to disclose, and because each patient is mentally and emotionally unique, there can be no single established custom concerning disclosure; if there is one, it is so general that it is of little value. Requiring the plaintiff to present expert

testimony that a standard does exist and was breached may well impose an insuperable burden. [61]

In the early 1970s, the courts and legislature in the United States realized that "the professional community standard of disclosure was inconsistent with patients' rights to make their own health care decisions." [62] In 1972, a new standard was established in the landmark case of *Canterbury v. Spence*. [63] This standard later became known as the "reasonable patient standard." It required the doctor "to disclose all material risks incident to the proposed therapy in order to secure an informed consent," [64] and gave rise to a new disclosure test: "the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked." [65] Under this standard, adequate disclosure "required the physician to discuss the nature of the proposed treatment, whether it was necessary or merely elective, the risks, and the available alternatives and their risks and benefits." [66]

The *Canterbury* court, however, warned that the standard does not mean "full disclosure" of all known risks. One commentator emphasized: [67]

Thus, the reasonable patient standard included more information than a professional community standard, but did not require the doctor to tell the patient all information about risks, benefits, alternatives, diagnosis, and the nature of the treatment. To do so would require the patient first to undergo complete medical training himself. "The patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required...." [emphasis supplied]

In *Sard v. Hardy*, [68] the Maryland Court of Appeals succinctly explained the rationale in adopting the reasonable patient standard first established in *Canterbury v. Spence*, [69] as follows:

In recent years, however, an ever-expanding number of courts have declined to apply a professional standard of care in informed consent cases, employing instead a general or lay standard of reasonableness set by law and independent of medical custom. These decisions recognize that protection of the patient's fundamental right of physical self-determination the very cornerstone of the informed consent doctrine mandates that the scope of a physician's duty to disclose therapeutic risks and alternatives be governed by the patient's informational needs. Thus, the appropriate test is not what the physician in the exercise of his medical judgment thinks a patient should know before acquiescing in a proposed course of treatment; rather, the focus is on what data the patient requires in order to make an intelligent decision.[Citations omitted]

Since then, this line of ruling has prevailed, as shown by the rulings discussed below on the need for expert evidence in the application of the preferred reasonable patient standard.

c. Expert Testimony in Ordinary Medical Negligence Cases

Philippine jurisprudence tells us that expert testimony is crucial, if not determinative of a physician's liability in a medical negligence case. [70] In litigations involving medical negligence as in any civil action, we have consistently ruled that the burden to prove by preponderance of evidence the essential elements - i.e., duty, breach, injury and proximate causation - rests with the plaintiff. Expert testimony is, therefore, essential since the factual issue of whether a physician or surgeon exercised the requisite degree of skill and care in the treatment of his patient is generally a matter of expert opinion. [71]

Cruz v. Court of Appeals, [72] a 1997 case, provided the first instance for the Court to elaborate on the crucial significance of expert testimony to show that a physician fell below the requisite standard of care. In acquitting the petitioner of the crime of reckless imprudence resulting in homicide because of a complete absence of any expert testimony of the matter of the standard of care employed by other physicians of good standing in the conduct of similar operations, the Court emphasized:

In the recent case of *Leonila Garcia-Rueda v. Wilfred L. Pacasio, et al.*, this Court stated that in accepting a

case, a doctor in effect represents that, having the needed training and skill possessed by physicians and surgeons practicing in the same field, he will employ such training, care and skill in the treatment of his patients. He therefore has a duty to use at least the same level of care that any other reasonably competent doctor would use to treat a condition under the same circumstances. It is in this aspect of medical malpractice that expert testimony is essential to establish not only the standard of care of the profession but also that the physician's conduct in the treatment and care falls below such standard. Further, inasmuch as the causes of the injuries involved in malpractice actions are determinable only in the light of scientific knowledge, it has been recognized that expert testimony is usually necessary to support the conclusion as to causation.

x x x The deference of courts to the expert opinion of qualified physicians stems from its realization that the latter possess unusual technical skills which laymen in most instances are incapable of intelligently evaluating. Expert testimony should have been offered to prove that the circumstances cited by the courts below are constitutive of conduct falling below the standard of care employed by other physicians in good standing when performing the same operation. It must be remembered that when the qualifications of a physician are admitted, as in the instant case, there is an inevitable presumption that in proper cases he takes the necessary precaution and employs the best of his knowledge and skill in attending to his clients, unless the contrary is sufficiently established. This presumption is rebuttable by expert opinion which is so sadly lacking in the case at bench. [Emphasis supplied]

Ramos v. Court of Appeals [73] meanwhile illustrates that in cases where the doctrine of *res ipsa loquitur* [74] is applicable, the requirement for expert testimony may be dispensed with. Thus, in finding that the respondent was negligent in the administration of anesthesia on the basis of the testimony of a dean of a nursing school and not of an anesthesiologist, the Court held:

We do not agree with the above reasoning of the appellate court. Although witness Cruz is not an anesthesiologist, she can very well testify upon matters on which she is capable of observing such as, the statements and acts of the physician and surgeon, external appearances, and manifest conditions which are observable by any one. This is precisely allowed under the doctrine of *res ipsa loquitur* where the testimony of expert witnesses is not required. It is the accepted rule that expert testimony is not necessary for the proof of negligence in non-technical matters or those of which an ordinary person may be expected to have knowledge, or where the lack of skill or want of care is so obvious as to render expert testimony unnecessary. We take judicial notice of the fact that anesthesia procedures have become so common, that even an ordinary person can tell if it was administered properly. As such, it would not be too difficult to tell if the tube was properly inserted. This kind of observation, we believe, does not require a medical degree to be acceptable. [75]

d. The Limited but Critical Role of Expert Testimony in Informed Consent Litigation

One of the major and fiercely contested issues in the growing number of informed consent cases in the United States is "whether it is necessary for the plaintiff to produce expert medical testimony to establish the existence and scope of a physician's duty to disclose risks of a proposed treatment." [76] A majority of legal commentators on the subject agree that "most courts will continue to require expert testimony to establish the existence and extent of a physician's duty to disclose risks of a proposed treatment, in view of the rule that expert testimony usually is necessary in medical malpractice cases generally." [77]

In informed consent cases (unlike in ordinary medical negligence cases), however, many issues do not necessarily involve medical science. In the landmark case of *Canterbury v. Spence*, [78] the United States Court of Appeals for the District Columbia Circuit defined the limited role of expert testimony in informed consent cases and provided examples of situations appropriate for non-expert testimony:

There are obviously important roles for medical testimony in such cases, and some roles which only medical

evidence can fill. Experts are ordinarily indispensable to identify and elucidate for the fact finder the risks of therapy and the consequences of leaving existing maladies untreated. They are normally needed on issues as to the cause of any injury or disability suffered by the patient and, where privileges are asserted, as to the existence of any emergency claimed and the nature and seriousness of any impact upon the patient from risk-disclosure. Save for relative infrequent instances where questions of this type are resolvable wholly within the realm of ordinary human knowledge and experience, the need for the expert is clear.

The guiding consideration our decisions distill, however, is that medical facts are for medical experts and other facts are for any witnesses-expert or not-having sufficient knowledge and capacity to testify to them. It is evident that many of the issues typically involved in nondisclosure cases do not reside peculiarly within the medical domain. Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment. Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision. These conspicuous examples of permissible uses of nonexpert testimony illustrate the relative freedom of broad areas of the legal problem of risk nondisclosure from the demands for expert testimony that shackle plaintiffs' other types of medical malpractice litigation. [Citations omitted; emphasis supplied]

This ruling underwent refinements in subsequent applications. The 1983 case of *Smith v. Shannon*, [79] - where the Supreme Court of Washington held that an expert testimony is required to establish initially the existence of the risk of the proposed treatment - is particularly instructive in its two-step discussion in the use of expert testimony in the application of the reasonable patient test. To quote from this case:

The determination of materiality is a 2-step process. Initially, the scientific nature of the risk must be ascertained, i.e., the nature of the harm which may result and the probability of its occurrence. The trier of fact must then decide whether that probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment.

While the second step of this determination of materiality clearly does not require expert testimony, the first step almost as clearly does. Only a physician (or other qualified expert) is capable of judging what risks exist and their likelihood of occurrence. The central reason for requiring physicians to disclose risks to their patients is that patients are unable to recognize the risks by themselves. Just as patients require disclosure of risks by their physicians to give an informed consent, a trier of fact requires description of risks by an expert to make an informed decision.

Some expert testimony is thus necessary to prove materiality. Specifically, expert testimony is necessary to prove the existence of a risk, its likelihood of occurrence, and the type of harm in question. Once those facts are shown, expert testimony is unnecessary. [Citations omitted, emphasis supplied]

In *Jambazian v. Borden*, [80] a 1994 case, the California Court of Appeals held that in proving his informed consent claim, the plaintiff was required "to present properly qualified medical opinion evidence that his alleged diabetic condition created surgical risks other than those related by defendant prior to the procedure." The Court held further:

In every case the court must be guided by the general rules governing the use of expert testimony. If the fact sought to be proved is one within the general knowledge of laymen, expert testimony is not required; otherwise the fact can be proved only by the opinions of experts." The diagnosis of diabetes, its magnitude, scientific characteristics, and the inherent risks associated with the condition are not matters of such common knowledge that opinion testimony is unnecessary in informed consent litigation to establish defendant should have disclosed the risks of surgery on a diabetic to plaintiff when there is no medical evidence that the illness exists.[Citations omitted.]

Betterton v. Leichtling, [81] another California Court of Appeals ruling, distinguished "between the use of expert testimony to prove the duty to disclose a known risk and the use of expert testimony to prove the existence of the risk itself" [82] and held that the effect of Betterton's aspirin use on the risk of surgical complications is subject to proof only by expert witnesses, viz:

Whether to disclose a significant risk is not a matter reserved for expert opinion. Whether a particular risk exists, however, may be a matter beyond the knowledge of lay witnesses, and therefore appropriate for determination based on the testimony of experts. Here, the effect of Betterton's aspirin use on the risk of surgical complications was a subject beyond the general knowledge of lay people. Therefore, the jury should have relied only on expert testimony when it determined whether the use of aspirin causes significant risks in surgery. [Citations omitted, emphasis supplied]

In Morhaim v. Scripps Clinic Medical Group, Inc. [83] that followed, the Court dismissed Morhaim's informed consent claim based on his failure to present expert testimony that diabetes is a risk of the Kenalog injections. The California Court of Appeals held:

Betterton and Jambazian make clear that while no expert testimony is required to establish a doctor's duty to disclose a "known risk of death or serious bodily harm," expert testimony is required to establish whether a risk exists in the first instance where the matter is beyond the knowledge of a lay person.

In this case, whether diabetes is a risk of the Kenalog injections Morhaim received is clearly a matter beyond the knowledge of a layperson. Therefore, Morhaim would have to present expert testimony regarding the existence of that risk in order to prevail on his informed consent claim. Once Morhaim's counsel conceded in his opening statement that Morhaim could not present such testimony, the trial court properly granted Scripps's motion for nonsuit.

All these, Canterbury v. Spence[84] best summed up when it observed that "medical facts are for medical experts and other facts are for any witness - expert or not - having sufficient knowledge and capacity to testify to them." [85]

V. Application to the Present Case

The issue in the present case is: Did the respondents prove by preponderance of evidence all the elements of a cause of action for medical negligence under the doctrine of informed consent?

As stated above, the plaintiff - as in any ordinary medical negligence action - bears the burden of proving the necessary elements of his or her cause of action. Canterbury v. Spence [86] tells us that informed consent plaintiffs also share this burden, viz:

In the context of trial of a suit claiming inadequate disclosure of risk information by a physician, the patient has the burden of going forward with evidence tending to establish prima facie the essential elements of the cause of action, and ultimately the burden of proof - the risk of nonpersuasion - on those elements. These are normal impositions upon moving litigants, and no reason why they should not attach in nondisclosure cases is apparent. [Citations omitted.]

In the present case, I find that the plaintiffs (the present respondents) utterly failed to establish their cause of action. They failed to establish their claim of lack of informed consent, particularly on the first and fourth elements.

a. First Element: Duty to Disclose Material Risks

As discussed, two competing standards are available to determine the scope and adequacy of a physician's disclosure - the professional disclosure standard or the reasonable patient standard.

While I concur with the results of the ponencia, I find its approach and reasoning in its use of the standards to be confused. The ponencia claims that "expert testimony must show the customary standard of care of physicians in the same practice as that of the defendant doctor," [87] thereby indicating its partiality to the use of the professional disclosure standard. At the same time, the ponencia felt "hesitant in defining the scope of mandatory disclosure in cases based on lack of informed consent, much less set a standard of disclosure," [88] citing lack of expert testimony in this regard. In plainer terms, it effectively said that the respondents failed to prove what must be disclosed. Yet, it also concluded that "there was adequate disclosure of material risks inherent in the chemotherapy procedure performed with the consent of Angelica's parents." [89]

After considering the American experience in informed consent cases, I opt to use the reasonable patient standard which focuses "on the informational needs of an average reasonable patient, rather than on professionally-established norms." [90] In the doctor-patient relationship, it is the patient who is subjected to medical intervention and who gets well or suffers as a result of this intervention. It is thus for the patient to decide what type of medical intervention he would accept or reject; it is his or her health and life that are on the line. To arrive at a reasonable decision, the patient must have sufficient advice and information; this is the reason he or she consults a doctor, while the role of the doctor is to provide the medical advice and services the patient asks for or chooses after informed consideration. [91]

In this kind of relationship, the doctor carries the obligation to determine and disclose all the risks and probabilities that will assist the patient in arriving at a decision on whether to accept the doctor's advice or recommended intervention. [92] While the disclosure need not be an encyclopedic statement bearing on the patient's illness or condition, the doctor must disclose enough information to reasonably allow the patient to decide.

In an informed consent litigation, American experiences documented through the decided cases, as well as our own common empirical knowledge and limited line of cases on medical negligence, tell us that at least the testimony on the determination of the attendant risks and the probabilities of the proposed treatment or procedure is a matter for a medical expert, not for a layperson, to provide. This is generally the first of the two-step process that *Smith v. Shannon*, cited above, speaks of [93] in describing the reasonable patient standard and its application.

The second step relates to testimony on the determination of the adequacy of the disclosure based on the materiality of the disclosed information to the patient's decision-making. In this regard, *Canterbury v. Spence* [94] again offers some help when it states:

Once the circumstances give rise to a duty on the physician's part to inform his patient, the next inquiry is the scope of the disclosure the physician is legally obliged to make. The courts have frequently confronted this problem but no uniform standard defining the adequacy of the divulgence emerges from the decisions. Some have said "full" disclosure, a norm we are unwilling to adopt literally. It seems obviously prohibitive and unrealistic to expect physicians to discuss with their patients every risk of proposed treatment - no matter how small or remote - and generally unnecessary from the patient's viewpoint as well. Indeed, the cases speaking in terms of "full" disclosure appear to envision something less than total disclosure, leaving unanswered the question of just how much. [95]

To my mind, the scope that this ruling describes, while not given with mathematical precision, is still a good rule to keep in mind in balancing the interests of the physician and the patient; the disclosure is not total by reason of practicality, but must be adequate to be a reasonable basis for an informed decision. For this aspect of the process, non-expert testimony may be used on non-technical detail so that the testimony may dwell on "a physician's failure to disclose risk information, the patient's lack of knowledge of the risk, and adverse consequences

following the treatment." [96]

In the present case, expert testimony is required in determining the risks and or side effects of chemotherapy that the attending physician should have considered and disclosed as these are clearly beyond the knowledge of a layperson to testify on. In other words, to prevail in their claim of lack of informed consent, the respondents must present expert supporting testimony to establish the scope of what should be disclosed and the significant risks attendant to chemotherapy that the petitioner should have considered and disclosed; the determination of the scope of disclosure, and the risks and their probability are matters a medical expert must determine and testify on since these are beyond the knowledge of laypersons. [97]

As expert witness, the respondents presented Dr. Balmaceda who testified on the physician's general duty to explain to the patient or to his relatives all the known side effects of the medical procedure or treatment. Specifically, Dr. Balmaceda gave the following expert opinion:

ATTY. NEPOMUCENO

Q: Madam Witness, what is the standard operating procedure before a patient can be subjected to procedures like surgery or administration of chemotheraphic (sic) drugs?

A: Generally, every physician base (sic) her or his assurance on the patient, on the mode of recovery by her or his personal assessment of the patient's condition and his knowledge of the general effects of the agent or procedure that will be allowed to the patient.

Q: What is the duty of the physician in explaining the side effects of medicines to the patient?

A: Every known side effects of the procedure or the therapeutic agents should really be explained to the relatives of the patient if not the patient.

Q: Right, what could be the extent of the side effect to the patient?

A: I said, all known side effects based on studies and observations.

Q: Should be?

A: Made known to the relatives of the patient or the patient.

Q: Then, after informing the relatives of the patient about [all the] side effects, what should be the next procedure?

WITNESS

A: The physician should secure consent from the relatives or the patient himself for the procedure for the administration of the procedure, the therapeutic agents.

ATTY. NEPOMUCENO

Q: Now, should the physician ask the patient's relatives whether they under[stood] the explanation?

A: Yes, generally, they (sic) should. [98]

On cross-examination, Dr. Balmaceda only clarified that all known side-effects of the treatment, including those that may aggravate the patient's condition, should be disclosed, viz:

ATTY. CASTRO

Q: And you mentioned a while ago, Madam Witness that all known side effects of drugs should be made known to the patient to the extent that even he dies because of making known the side effect, you will tell him?

A: I said, all known side effect[s] should be made known to the relatives or to the patient so that consent and the responsibility there lies on the patient and the patient's relatives.

Q: So, even that information will aggravate his present condition?

A: Making known the side effect?

A: Yes.

A: In my practice, I did not encounter any case that will aggravate it. I make him know of the side effect[s] and if indeed there is, I think the person that should approve on this matter should be the relatives and not the patient. It is always the patient that become (sic) aggravated of the side effects of the procedure in my experience. [99]

Unfortunately for the respondents, Dr. Balmaceda's testimony failed to establish the existence of the risks or side-effects the petitioner should have disclosed to them in the use of chemotherapy in the treatment of osteosarcoma; the witness, although a medical doctor, could not have testified as an expert on these points for the simple reason that she is not an oncologist nor a qualified expert on the diagnosis and treatment of cancers. [100] Neither is she a pharmacologist who can properly advance an opinion on the toxic side effects of chemotherapy, particularly the effects of Cisplatin, Doxorubicin and Cosmegen - the drugs administered to Angelica. As a doctor whose specialty encompasses hospital management and administration, she is no different from a layperson for purposes of testifying on the risks and probabilities that arise from chemotherapy.

In the analogous case of *Ramos v. Court of Appeals* [101] that dwelt on the medical expertise of a witness, we held that a pulmonologist cannot be considered an expert in the field of anesthesiology simply because he is not an anesthesiologist:

First of all, Dr. Jamora cannot be considered an authority in the field of anesthesiology simply because he is not an anesthesiologist. Since Dr. Jamora is a pulmonologist, he could not have been capable of properly enlightening the court about anesthesia practice and procedure and their complications. Dr. Jamora is likewise not an allergologist and could not therefore properly advance expert opinion on allergic-mediated processes. Moreover, he is not a pharmacologist and, as such, could not have been capable, as an expert would, of explaining to the court the pharmacologic and toxic effects of the supposed culprit, Thiopental Sodium (Pentothal).

x x x x

An anesthetic accident caused by a rare drug-induced bronchospasm properly falls within the fields of anesthesia, internal medicine-allergy, and clinical pharmacology. The resulting anoxic encephalopathy belongs to the field of neurology. While admittedly, many bronchospastic-mediated pulmonary diseases are within the expertise of pulmonary medicine, Dr. Jamora's field, the anesthetic drug-induced, allergic mediated bronchospasm alleged in this case is within the disciplines of anesthesiology, allergology and pharmacology. On the basis of the foregoing transcript, in which the pulmonologist himself admitted that he could not testify about the drug with medical authority, it is clear that the appellate court erred in giving weight to Dr. Jamora's testimony as an expert in the administration of Thiopental Sodium.

x x x x

Generally, to qualify as an expert witness, one must have acquired special knowledge of the subject matter about which he or she is to testify, either by the study of recognized authorities on the subject or by practical experience. Clearly, Dr. Jamora does not qualify as an expert witness based on the above standard since he lacks the necessary knowledge, skill, and training in the field of anesthesiology. Oddly, apart from submitting testimony from a specialist in the wrong field, private respondents intentionally avoided providing testimony

by competent and independent experts in the proper areas. [102]

At best, Dr. Balmaceda's testimony only established generally the petitioner's duty to disclose all the known risks of the proposed treatment and nothing more. Even if this testimony is deemed competent, its probative value - on the risks attendant to chemotherapy and the probabilities that the attending chemotherapy specialist should have considered and disclosed to the patient and her parents - cannot but be negligible for lack of the required capability to speak on the subject of the testimony.

In this regard, Justice Carpio proffers the view that the petitioner "as an expert in oncology identified [in the present case] the material risks and side effects of chemotherapy." [103] To support his conclusion, Justice Carpio cites jurisprudence which allowed the use of the defendant-physician's expert testimony to prove the medical disclosure standard in the community. [104] I cannot subscribe to this point of view.

Arguably, the medical disclosure standard can be established through the petitioner's own expert testimony, as has been done in some courts in the United States in cases where the defendant physician testified that he did disclose the risks, but the plaintiff denied it. [105] In these cases, the defendant physicians are qualified as expert witnesses and their testimonies are considered expert medical testimony insofar as they disclose the practice of competent and responsible medical practitioners in a particular medical situation. [106]

Reliance on this line of cases for purposes of the present case is however, inapt.

First, these cases are appropriate only if we are to adopt the professional disclosure or the "physician standard" - a standard that Justice Carpio himself admits "is not the modern and prevailing standard among United States courts." Citing *Cantebury v. Spence*, [107] Justice Carpio declares that the "prevailing trend among courts is to use the patient standard of materiality." As held in *Febud v. Barot*: [108]

Sufficiency of disclosure under the prudent patient standard requires that disclosure be viewed through the mind of [the] patient, not [the] physician. Implicit in this shift of emphasis is recognition that expert testimony is no longer required in order to establish the medical community's standard for disclosure and whether the physician failed to meet that standard.

Second, this line of cases also cannot apply to the present case since the petitioner's testimony, on its own, did not establish the medical standard in obtaining consent for chemotherapy treatment. Stated differently, the petitioner's testimony did not specifically refer to the prevailing medical practice insofar as what risks or side-effects of chemotherapy should be disclosed to the respondents. In fact, during the trial, the respondents failed to elicit any expert testimony from the petitioner regarding the recognized standard of care in the medical community about what risks of chemotherapy should have been disclosed to them.

b. Second Element: Adequacy of Disclosure of Risks

The ponencia concludes that "there was adequate disclosure of material risks of the [chemotherapy administered] with the consent of Angelica's parents" in view of the fact that the petitioner informed the respondents of the side effects of chemotherapy, such as low white and red blood cell and platelet count, kidney or heart damage and skin darkening.

I cannot agree with this conclusion because it was made without the requisite premises. As heretofore discussed, sufficiency of disclosure can be made only after a determination and assessment of risks have been made. As discussed above, no evidence exists showing that these premises have been properly laid and proven. Hence, for lack of basis, no conclusion can be made on whether sufficient disclosure followed. In other words, the disclosure cannot be said to be sufficient in the absence of evidence of what, in the first place, should be disclosed.

Even assuming that the ponencia used the professional disclosure standard in considering the material risks to be disclosed, the existing evidence still does not support the conclusion arrived at. The reason again is the respondent's failure to establish a baseline to determine adequacy of disclosure; in the case of the professional disclosure standard, determination of adequacy requires expert medical testimony on the standard medical practice that prevails in the community. Thus, it has been held that "[e]xpert testimony is required in an informed consent case to establish what the practice is in the general community with respect to disclosure of risks that the defendant physician allegedly failed to disclose." [109]

Lastly, the respondent Lina Soliman's testimony on this point bears close examination in light of the totality of the evidence adduced. A first consideration is the nature of the illness of the deceased - osteosarcoma - that according to the undisputed expert testimony of Dr. Tamayo is a "very aggressive type of cancer that requires adjuvant chemotherapy." In plainer terms, the amputation of Angelica's right leg was not sufficient, chemotherapy must follow; despite modern chemotherapy, the mortality rate of osteosarcoma is 80 to 90%. [110] In light of this expert testimony, the respondent Lina Soliman's testimony that she was assured of a 95% chance of healing (should Angelica undergo chemotherapy) by the petitioner cannot be accepted at face value.

A second consideration is that the claim of a 95% chance of healing cannot also be given any credence considering the respondent Lina Soliman's inconsistent testimony on this point. In fact, the record bears out that the respondent Lina Soliman testified on direct examination that the petitioner assured her of a 95% chance of healing. However, she contradicted her earlier testimony, when on rebuttal, she declared that the petitioner gave her a 90% guarantee of full recovery should Angelica undergo chemotherapy.

A third consideration is that specific disclosures such as life expectancy probabilities" [111] are not legally necessary or "required to be disclosed in informed consent situations," [112] thus the respondent Lina Soliman's testimony on this point cannot be given any probative value. Thus, in the landmark case of *Arato v. Avedon* [113] - where family members of a patient who died of pancreatic cancer brought an informed consent action against defendant physicians who failed to provide the patient material information (statistical life expectancy) necessary for his informed consent to undergo chemotherapy and radiation treatment [114] - the Supreme Court of California "rejected the mandatory disclosure of life expectancy probabilities" [115] on account "of the variations among doctor-patient interactions and the intimacy of the relationship itself." [116]

Likewise, the statement that the side effects were confined to hair loss, vomiting and weakness can hardly be given full credit, given the petitioner's own testimony of what she actually disclosed. Respondent Lina Soliman's testimony, tailor-fitted as it is to an informed consent issue, should alert the Court to its unreliability. Even if given in good faith, it should, at best reflect what the respondents heard (or chose to hear), not what the petitioner disclosed to them - a common enough phenomenon in high-stress situations where denial of an unacceptable consequence is a first natural response. That death may occur is a given in an osteosarcoma case where the most drastic intervention - amputation - has been made. That death was not proximately caused by the chemotherapy (as testified to by experts and as discussed below) demonstrates its particular relevance as a consequence that the doctor administering the chemotherapy must disclose.

c. Fourth Element: Causation

In addition to the failure to prove the first element, I also submit that the respondents failed to prove that the chemotherapy administered by the petitioner proximately caused the death of Angelica Soliman.

Traditionally, plaintiffs alleging lack of informed consent must show two types of causation: 1) adequate disclosure would have caused the plaintiff to decline the treatment, and 2) the treatment proximately caused injury to the plaintiff. The second causation requirement is critical since a medical procedure performed without

informed consent does not, in itself, proximately cause an actionable injury to a plaintiff; a plaintiff must show that he or she has suffered some injury as a result of the undisclosed risk to present a complete cause of action. [117]

In the recent case of *Gorney v. Meaney*, [118] the Arizona Court of Appeals held that expert testimony is essential to demonstrate that the treatment proximately caused the injury to the plaintiff, viz:

Expert testimony is not required for the first type of causation because it is plainly a matter to which plaintiffs themselves could testify and is within the knowledge of the average layperson.

Expert testimony is required, however, to demonstrate that the treatment proximately caused injury to the plaintiff. Such testimony helps to ensure that the plaintiff's alleged injury was not caused by the progression of a pre-existing condition or was the result of some other cause, such as natural aging or a subsequent injury x x x. Thus, *Gorney's* expert opinion affidavit should have stated that the surgery proximately caused an injury to *Gorney*, e.g., the "worsen[ed]" condition in *Gorney's* knee. [Citations omitted, emphasis supplied]

In the present case, respondent Lina Soliman's lay testimony at best only satisfied the first type of causation - that adequate disclosure by the petitioner of all the side effects of chemotherapy would have caused them to decline treatment. The respondents in this case must still show by competent expert testimony that the chemotherapy administered by the petitioner proximately caused Angelica's death.

In this regard, the respondents presented Dr. Vergara as an expert witness, who gave the following opinion:

ATTY. NEPOMUCENO

Q: Under the word conclusions are contained the following words: "Cause of death is hypovolemic shock secondary to multiple organ hemorrhages and disseminated Intravascular Coagulation," in layman's term, what is the meaning of that?

WITNESS

A: The victim died of hemorrhages in different organs and disseminated intravascular coagulation is just a complication.

ATTY. NEPOMUCENO

Q: Madam Witness, what could have caused this organ hemorrhages and disseminated intravascular coagulation?

A: The only thing I could think of, sir, was the drugs given to the victim, the chemical agents or this anti-plastic drugs can cause x x x the reduction in the platelet counts and this could be the only cause of the bleeding.

Q: And that bleeding could have been sufficient to cause the death of Angelica Soliman?

A: Yes, Sir. [119]

On cross-examination, Dr. Vergara admitted that the opinions she advanced to the court were not based on her opinion as an expert witness but on the interview she had previously conducted with an oncologist, viz:

ATTY. CASTRO

Q: Now, you mentioned chemotherapy, Madam Witness, that it is not a treatment really, are you initiating that?

A: Sir, I asked for an opinion from an Oncologist, and she said that only one person really survived the 5-year

survival rate. Only one person.

Q: That is, are you referring to malignant osteosarcoma?

A: Yes, sir. [120]

x x x x

ATTY. AYSON

Q: Madam Witness, you said a while ago that you are not a pathologist?

A: Yes, sir.

Q: And during the cross-examination and the re-direct, you admitted that you have had to refer or interview an oncologist?

A: Yes, sir.

Q: What is an oncologist Madam?

A: She is a doctor in cancers.

Q: So, whatever opinion you have stated before this Honorable Court [is] based on the statement made by the oncologist you have interviewed?

A: Only for the disease osteosarcoma.

x x x x

COURT

Q: So then, the opinion you gave us that the patient afflicted with cancer of the bone, osteosarcoma that she will live for 5 years is not of your own opinion but that of the oncologist?

A: Yes, your Honor, but that 5 years survival is only for patients undergoing chemotherapy but actually it is less than 5 years.

Q: You mean to tell the Court Mrs. Witness that the patient has been diagnosed [with] cancer, may still have a life span of five (5) years after examination having been found to have cancer?

A: No, sir. Less than five (5) years.

Q: In this particular case, what was the information given you by the Oncologist you consulted?

A: Only one person lived after she was given chemotherapy, five years sir.

Q: In this particular case, the Oncologist you consulted also told you that the patient Soliman did not die of cancer but died of complication, is that correct?

A: Yes, sir.

Q: So, it was not actually your own observation?

A: Sir, considering my findings at the body or the different organs, of the victim, I have said I found hemorrhages, so I think that is enough to have caused the death of the victim. [121]

Under these terms, Dr. Vergara's expert testimony was clearly incompetent to prove that the chemotherapy proximately caused Angelica's demise for two reasons.

First, Dr. Vergara, who is an autopsy expert, is not qualified to be an expert witness in an osteosarcoma case involving chemotherapy. Her admission that she consulted an oncologist prior to her testimony in court confirms this. Dr. Vergara is also not a pharmacologist who can competently give expert opinion on the factual issue of whether the toxic nature of the chemotherapy proximately caused Angelica's death. As previously stated, the respondents failed to present competent experts in the field of oncology despite their representation to do so during trial.

Second, Dr. Vergara's testimony is doubly incompetent as it is hearsay; her opinions were not based on her own knowledge but based on the opinion of another oncologist she previously interviewed.

Additionally, I cannot help but note that Dr. Vergara could not have adequately testified regarding the medical condition and the cause of death of Angelica without referring to her medical records. As the records of the case show, these medical records were never introduced into evidence by either party to the case. The absence of these medical records significantly lessened the probative value of Dr. Vergara's testimony regarding the causation of Angelica's death.

Thus, in the absence of competent evidence that the chemotherapy proximately caused Angelica's death, what stands in the record in this case is the petitioner's uncontroverted and competent expert testimony that Angelica died of sepsis brought about by the progression of her osteosarcoma - an aggressive and deadly type of bone cancer. That the petitioner is a competent expert witness cannot be questioned since she was properly qualified to be an expert in medical oncology.

In this respect, the petitioner - who is a board certified medical oncologist with thirteen (13) years of experience in the treatment of osteosarcoma - testified that Angelica died of sepsis, viz:

Q: Now, despite all these medications, the patient has been deceased on September 1, 1993, what do you think can be the cause of x x x death of the patient?

A: This is probably the cause of death[-]overwhelming infection that has gone through her body that has also caused her other organs or systems to fail and this is also because of poor defense mechanism brought about from the cancer per se. [122]

On cross-examination, the petitioner rebutted the respondents' theory that the chemotherapy caused platelet reduction and the massive bleeding that ultimately caused Angelica's death, viz:

Q: Would you agree with me if I say that the platelet reduction triggered a chain of physiological pathological mechanism in the body of Angelica Soliman which eventually triggered her death?

A: No, sir.

Q: Why not?

A: Because the platelet decrease was not the main cause of death of Angelica Soliman, it was an overwhelming infection which also triggered the reduction of platelets.

Q: So, which came ahead, the overwhelming infection or the platelet reduction?

A: The infection, sir.

Q: And you said overwhelming?

A: Because we were talking about the death.

Q: No, no, no. You said that the infection that attacked Angelica Soliman was overwhelming, will you define

what you mean by overwhelming?

A: Overwhelming is a condition wherein the infection has already gone to other parts of the body and caused the decrease in the function of the organs and systems.

x x x x

Q: And you are saying that the platelet reduction eventually led to the bleeding and the bleeding led to the death?

A: No, sir.

Q: Why not?

A: Because we were able to control the bleeding of Angelica Soliman because of the transfusion that we were giving her with platelets. We were able to stall the bleeding but the infection was there and it was the infection that was hard to control.

x x x x

Q: Now, would I be correct if I say that any or all of these three drugs could cause the platelet reduction in the body of Angelica Soliman?

A: Theoretically, yes, sir.

Q: Practically, what do you mean?

A: Practically, we see usually a decrease in platelets, usually after three cycles of chemotherapy but not on the initial chemotherapy. In the initial chemotherapy the usual blood elements which is decreased is in the white cells of the body. [123]

Q: Alright, at what point and time did it ever occur to your mind that said infection would develop into sepsis?

A: I think it changed the following day.

Q: It was the fifth day already?

A: Yes, sir.

Q: And you changed [the] antibiotic?

A: [I] changed it into something stronger, sir.

Q: What transpired?

A: She was given Fortum intravenously.

x x x x

Q: By sepsis, meaning that the germs, the bacteria were already in the blood system, is that correct?

A: Yes, beginning.

x x x x

Q: What about Fortum did it take effect?

A: No, sir.

Q: Why not?

A: The patient has been going down ever since and the white cells were down for it was not enough to control the infection because there was nothing in her body to fight and help Fortum fight the infection, that is why, we also add (sic) another medicine that would increase her white cell count called Leucomax.

Q: And did Leucomax help?

A: No, sir. [124]

Q: Of the 500 patients, you said you treated before, how many developed sepsis?

A: I will say 1/5 developed sepsis.

Q: And of the 1/5 that developed sepsis before Angelica Soliman, how many died?

A: Seventy percent (70%).

Q: Died?

A: Yes, sir. [125]

Justice Carpio is of the view that the facts as stated by the RTC and the Court of Appeals clearly show that the chemotherapy caused Angelica's death. [126]

I disagree. As heretofore discussed, in the absence of competent expert testimony, the Court has no factual basis to declare that the chemotherapy administered by the petitioner proximately caused Angelica's death. Our ruling in *Cruz v. Court of Appeals* is instructive: [127]

But while it may be true that the circumstances pointed out by the courts below seemed beyond cavil to constitute reckless imprudence on the part of the surgeon, this conclusion is still best arrived at not through the educated surmises nor conjectures of laymen, including judges, but by the unquestionable knowledge of expert witnesses. For whether a physician or surgeon has exercised the requisite degree of skill and care in the treatment of his patient is, in the generality of cases, a matter of expert opinion. [Emphasis supplied]

In sum, the respondents failed to prove by appropriate evidence - i.e., by expert testimony - that Angelica's death was caused by the chemotherapy the petitioner administered. This failure in establishing the fourth requisite of the respondents' cause of action fatally seals the fate of the respondent's claim of medical negligence due to lack of informed consent.

On the basis of the foregoing, I vote to grant the petition.

[1] Decision, p. 18.

[2] *Flores v. Pineda*, G.R. No. 158996, November 14, 2008, 571 SCRA 83, 91.

[3] *Davis v. Kraff*, N.E.2d 2010 WL 4026765 III. App. 1 Dist. 2010, citing *Coryell v. Smith*, 274 III. App. 3d 543, 210 III. Dec. 855, 653 N.E.2d 1317 (1995).

[4] *Supra* note 2.

[5] *Rollo*, p. 34.

[6] *TSN*, January 26, 1995, p. 3.

[7] Petitioner's Answer dated March 28, 1994; *rollo*, p. 96.

[8] *Id.* at 97.

- [9] Respondents' Complaint dated February 21, 1994, Id. at 81.
- [10] Id. at 174.
- [11] Id. at 35.
- [12] Id. at 89.
- [13] Supra note 8 at 81-82.
- [14] Supra note 6 at 95-108.
- [15] Id. at 119-162.
- [16] Id. at 33-63.
- [17] TSN, December 14, 1994, pp. 12-14.
- [18] Id. at 58.
- [19] TSN, January 27, 1997, p. 3.
- [20] Id. at 5.
- [21] TSN, December 15, 1994, p. 5-6.
- [22] rollo, p. 52.
- [23] TSN, December 14, 1994, pp. 7-8.
- [24] Id. at 24-25.
- [25] Id. at 39.
- [26] Id. at 40.
- [27] TSN, April 28, 1995, pp. 9-11.
- [28] Id. at 22-24.
- [29] Id. at 27.
- [30] Id. at 15 and 27.
- [31] TSN, October 6, 1995, pp. 5-15.
- [32] Id. at 22-27.
- [33] Id. at 33-34.
- [34] Id. at 39.
- [35] TSN, May 20, 1996, pp. 8-9.
- [36] Id. at 12.
- [37] Decision, pp. 18-19.
- [38] Id. at 19-20.
- [39] Bryan J. Warren, *Pennsylvania Medical Informed Consent Law: A Call To Protect Patient Autonomy Rights*

By Abandoning The Battery Approach, 38 Duq. L. Rev. 917, 927 (2000). In American perspective, battery is "[a] harmful or offensive contact with a person, resulting from an act intended to cause the plaintiff or a third person to suffer such a contact." *Infra* note 35, at 890, citing W. Keeton, D. Dobbs R. Keeton, R. Keeton & D. Owen, *Prosser & Keeton on The Law of Torts*, § 9, at 39 (5th ed. 1984).

[40] 105 N.E. 92, 93 (N.Y. 1914).

[41] *Supra* note 39.

[42] *Id.* at 928.

[43] *Id.* at 929.

[44] Richard E. Shugrue & Kathryn Linstromberg, *The Practitioner's Guide To Informed Consent*, 24 *Creighton L. Rev.* 881, 893 (1991).

[45] 154 *Cal. App. 2d* 560, 317 *P.2d* 170.

[46] *Supra* note 39, at 930.

[47] *Supra* note 44, at 893.

[48] *Id.* at 883.

[49] 186 *Kan.* 393, 350 *P.2d* 1093 (1960).

[50] *Supra* note 39, at 930.

[51] *Supra* note 49.

[52] 334 *S.W.2d* 11 (Mo. 1960).

[53] *Supra* note 44, at 894.

[54] *Ibid.*

[55] 8 *Cal.3d* 229, 502 *P.2d* 1, 104 *Cal. Rptr.* 505.

[56] *Supra* note 39, at 931.

[57] *Id.* at 923.

[58] *Supra* note 49.

[59] *Supra* note 44, at 899.

[60] *Id.* at 900-901.

[61] *Id.* at 901.

[62] *Id.* at 902.

[63] 464 *F.2d* 772, 150 *U.S. App. D.C.* 263 (1972).

[64] *Supra* note 62.

[65] *Supra* note 44, at 903.

[66] *Ibid.*

[67] Id. at 903-904.

[68] 281 Md. 432, 379 A.2d 1014 Md. 1977.

[69] Supra note 63.

[70] See Cruz v. Court of Appeals, G.R. No. 122445, November 18, 1997, 282 SCRA 188; Flores v. Pineda, supra note 2; Cayao-Lasam v. Ramolete, G.R. No. 159132, December 18, 2008, 574 SCRA 439.

[71] Flores v. Pineda, supra note 2.

[72] Supra note 70, at 189-190.

[73] G.R. No. 124354, December 29, 1999, 321 SCRA 584.

[74] Res ipsa loquitur is a Latin phrase which literally means "the thing or the transaction speaks for itself." The phrase "res ipsa loquitur" is a maxim for the rule that the fact of the occurrence of an injury, taken with the surrounding circumstances, may permit an inference or raise a presumption of negligence, or make out a plaintiff's prima facie case, and present a question of fact for defendant to meet with an explanation. Id. at 598.

[75] Id. at 609-610.

[76] 52 ALR 3d 1084.

[77] Ibid.

[78] Supra note 63.

[79] 100 Wash.2d 26, 666 P.2d 351.

[80] 25 Cal. App. 4th 836.

[81] 101 Cal. App. 4th 749 (2002).

[82] Infra note 83.

[83] 2005 WL 237772 (Cal.App.4 Dist.).

[84] Supra note 63.

[85] Ibid.

[86] Supra note 63.

[87] Decision, p. 20.

[88] Id.

[89] Supra note 1.

[90] Supra note 44, at 902.

[91] See Miller v. Kennedy, 11 Wash.App. 272, 522 P.2d 852 (1974) where the Washington Court of Appeals emphasized that it is for the patient to evaluate the risks of treatment and that the only role to be played by the physician is to provide the patient with information as to what those risks are. Supra note 72.

[92] See Cobbs v. Grant, supra note 53 where the Supreme Court of California held: "[T]he patient, being unlearned in medical sciences, has an abject independence upon and trust in his physician for the information

upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions."

[93] Supra note 79.

[94] Supra note 63.

[95] Id. at 786.

[96] Supra note 63.

[97] *Turner v. The Cleveland Clinic Foundation*, 2002 WL 31043137 (Ohio App. 8 Dist.), citing *Harris v. Ali* (May 27, 1999), Cuyahoga App. No. 73432, citing *Ratcliffe v. University Hospitals of Cleveland* (March 11, 1993), Cuyahoga App. No. 61791, citing *Ware v. Richey*, 14 Ohio App.3d 3, 7, 469 N.E.2d 899.FN1.

[98] TSN, April 28, 1995, pp. 22-24.

[99] Id. at 25.

[100] Supra note 30.

[101] Supra note 72.

[102] Id. at 614-616.

[103] Justice Carpio asserts that the petitioner testified and admitted that the following are the risks and side effects of chemotherapy: (1) Falling hair; (2) Nausea; (3) Vomiting; (4) Loss of appetite; (5) Lowering of white blood cell count; (6) Lowering of red blood cell count; (7) Lowering of platelet count; (8) Sterility; (9) Damage to kidneys; (9) Damage to the heart; (11) Skin darkening; (12) Rashes; (13) Difficulty in breathing; (14) Fever; (15) Excretion of blood in the mouth; (16) Excretion of blood in the anus; (17) Development of ulcers in the mouth; (18) Sloughing off of skin; (19) Systemic Lupus Erythematosus; (20) Carpo-pedal spasm; (21) Loose bowel movement; (22) Infection; (23) Gum bleeding; (24) Hypovolemic shock; (25) Sepsis; (26) Death after 13 days. Dissenting Opinion, pp. 6-7.

A close scrutiny of the evidence on record reveals otherwise. In her Answer, the petitioner only mentioned the following side-effects of chemotherapy: (1) falling hair; (2) nausea and vomiting; (3) Loss of appetite; (4) low count of white blood cells, red blood cells and platelets, (5) possible sterility, (6) damage to the heart and kidneys, and (7) darkening of skin. Supra note 7. During trial, the petitioner testified that she mentioned only the following side effects of chemotherapy to the respondents: hair loss, nausea, vomiting, sterility, and low and white blood cells and platelet count. Supra note 31.

[104] Dissenting Opinion, p. 5.

[105] 88 A.L.R.3d 1008 citing *Hood v Phillips* (1977, Tex) 554 SW2d 160.

[106] *Nishi v. Hartwell*, 52 Haw. 188, 473 P.2d 116 (1970) citing *Vigil v. Herman*, 102 Ariz. 31, 424, P.2d 159 (1967); *Sheffield v. Runner*, 163 Cal.App.2d 48, 328 P.2d 828 (1958); *McPhee v. Bay City Samaritan Hospital*, 10 Mich.App. 567, 159 N.W.2d 880 (1968); *Wilson v. Scott*, 412 S.W.2d 299 (Tex.1967).

[107] Supra note 63.

[108] 260 NJ Super 322, 616 A2d 933 (1992).

[109] Supra note 76 citing *Giles v. Brookwood Health Services, Inc.*, 5 So. 3d 533 (Ala. 2008). The case of *Williams v. Menehan* (1963) 191 Kan 6, 379 P2d 292 is instructive. In that case, "the parents of a child who died

during a heart catheterization alleged that they were not informed of all of the risks of the diagnostic procedure." "The court [in] affirming a judgment for the defendant doctors, ... applied the rule that when a doctor makes an allegedly partial disclosure of risks of a proposed treatment, the plaintiff must produce expert testimony to establish the inadequacy of the doctor's disclosure. The court noted that the plaintiff parents had offered no testimony of what a reasonable physician would have disclosed under the same or similar circumstances." Supra note 76.

[110] Supra note 36.

[111] Arato v. Avedon, 5 Cal.4th 1172, 858 P.2d 598, 23 Cal.Rptr.2d 131.

[112] Id. See also infra note 114.

[113] Id.

[114] William J. McNichols, Informed Consent Liability In A "Material Information Jurisdiction: What Does The Future Portend?, 48 Okla. L. Rev. 711,742 (1996).

[115] Id. at 743.

[116] Denise Ann Dickerson, A Doctor's Duty To Disclose Life Expectancy Information To Terminally Ill Patients, 43 Clev. St. L. Rev. 319, 343 (1995).

[117] Gorney v. Meaney, 214 Ariz. 226, 150 P.3d 799, citing Shetter v. Rochelle, 2 Ariz.App. 358, 367, 409 P.2d 74, 83 (1965); William L. Prosser and W. Page Keeton, The Law of Torts § 32, at 191 5th ed. (1984); see also Hales, 118 Ariz. at 311, 576 P.2d at 499; McGrady v. Wright, 151 Ariz. 534, 537, 729 P.2d 338, 341 (App.1986); Gurr v. Willcutt, 146 Ariz. 575, 581, 707 P.2d 979, 985 (App.1985).

[118] Ibid.

[119] TSN, December 14, 1994, pp. 24-25.

[120] Id. at 36.

[121] Id. at 39-40.

[122] TSN, October 6, 1995, p. 33.

[123] Id. at 37-39.

[124] Id. at 53-55.

[125] Id. at 61-62.

[126] Dissenting Opinion, pp. 10-11.

[127] Supra note 70.

CONCURRING OPINION

ABAD, J.:

I join the opinion of the majority of my colleagues as well as that of Justice Arturo D. Brion. I write this concurring opinion out of the belief that, ultimately, the issue in this case rests on a question of fact.

Plaintiffs Reynaldo and Lina Soliman claim damages against defendant Dr. Rubi Li for her failure to sufficiently inform them before hand of the risks of complications, pains, and quick death that their sick daughter, Angelica, faced when placed under chemotherapy.

As the majority points out, the Solimans had the burden of proving the following to be entitled to damages: 1) that Dr. Li had a duty to disclose the material risks of placing Angela under chemotherapy; 2) that the doctor failed to disclose or inadequately disclosed those risks; 3) that as a direct and proximate result of the failure to disclose, the Solimans consented to have Angela undergo such therapy that they otherwise would not have consented to; and 4) that Angela suffered injury on account of the chemotherapy.

The Key Issue of Fact

The key issue in this controversy, to my mind, is whether or not Dr. Li failed to disclose or inadequately disclosed to the Solimans the risks of chemotherapy for their daughter since Dr. Li and the Solimans gave opposing versions of what were disclosed.

The Plaintiffs' evidence

Lina Soliman (Lina) testified that in the summer of 1993 she noticed her daughter Angelica walking with some difficulty. She brought her to a hospital in Bicol where she was diagnosed with a malignant tumor in her right knee. They then went to the National Children's Medical Center in Manila for a second opinion but the doctor who attended her gave the same view.

On July 7, 1993 Lina brought Angelica to St. Luke's Medical Center for a biopsy of tissues taken from her ailing leg. Dr. Tamayo, whom the Solimans consulted, later told them that their daughter had cancer and her leg had to be severed to prevent the disease from spreading. Still, the procedure, he said, offered only a 50% chance that it would contain the spread of the malignant cells. With the Solimans' consent, the doctor amputated the affected leg from above the knee on July 23, 1993. Dr. Tamayo then referred Angela to Dr. Li for chemotherapy.

Before starting the chemotherapy, Dr. Li told Lina when they met its three possible side-effects: vomiting, hair loss, and weakening. When Lina asked Dr. Li if the chemotherapy had any other possible effects, she replied in the negative. The chemotherapy was originally set for August 12, 1993 but had to be reset because the Solimans returned to Bicol for a rest. Lina called up Dr. Li about the deferment and during that call she asked the doctor anew about the effects of the drugs that she would use on Angelica. Dr. Li repeated the three side effects she earlier mentioned.

When Angelica checked in at St. Luke's on August 18, Dr. Li came to administer dextrose to her. On this occasion, Dr. Li told the Solimans that Angela had a 95% chance of becoming normal again after the chemotherapy. Lina asked the doctor anew about the side-effects and the latter said the same thing: falling hair, vomiting, and weakness.

Dr. Li first administered the drugs for chemotherapy to Angela on August 19. That night, Angelica started vomiting. Lina asked the attending nurse about it but the latter said that it was just an effect of the drugs. The treatment continued on the second day and so did the vomiting. On the third day of chemotherapy, Lina observed redness all over Angelica's face. She asked Dr. Li about this but the doctor told her that it was only a reaction to the drugs.

On the fourth day, the discoloration on Angela's face grew darker and spread to the neck and chest. Dr. Li assured Lina that this was an effect of the drugs. During the following days, Angelica complained of chest pains and difficulty in breathing, prompting Dr. Li to administer oxygen to her. As Lina saw that her daughter could not bear it anymore, she asked Dr. Li to stop the chemotherapy. Angelica passed black stool and had reddish urine.

Dr. Li explained that this, too, was a reaction to the drugs. Lina wanted Angelica discharged but she had to be confined because of convulsion, which Dr. Li treated by giving her calcium.

Afterwards, when Angelica's nose and mouth secreted blood, Dr. Li attributed this to the lowering of her platelet count. They decided to move her to the hospital's intensive care unit for closer monitoring. After getting blood transfusion, Angelica's vomiting lessened but the color of her skin darkened. Later, her skin "shredded by just rubbing cotton on it." She vomited blood and her convulsions resumed to the point that she became hysterical and said "ayaw ko na." She passed away soon after.

Reynaldo Soliman (Reynaldo), Angelica's father, testified that they consulted with a number of doctors from the Ago Medical and Educational Center, the UERM Medical Center, and the National Children's Hospital regarding Angelica's case. After her amputation at St. Luke's hospital, they returned to Bicol but, on Dr. Tamayo's advice, Reynaldo decided to have Angelica undergo chemotherapy. She was readmitted at St. Luke on August 18, 1993. When Reynaldo met Dr. Li on August 19, he asked her about the effects of chemotherapy on his daughter. She replied that Angelica would manifest falling hair, vomiting, and weakness.

Angelica showed no reaction to the chemotherapy on its first day. On the next day, however, redness appeared on her face and she started vomiting. Upon inquiry from Dr. Li, she told them that this was normal. On August 23 Angelica appeared very weak. When asked about this, Dr. Li said that it was a normal reaction. Seeing the effects of chemotherapy, Reynaldo advised the doctor to stop the treatment. As they were settling the bills the next day, Angelica had an epileptic fit. It took a while for a doctor to come and give her calcium injection to calm her down. Angelica had another convulsion the next day. They again gave her calcium.

Dr. Li moved Angelica to another room to ward off infection. But she bled through her mouth. As Dr. Li could not be located, a certain Dr. Marbella came and told him that Angelica's blood platelets had gone down. They gave her continuous blood transfusions but the bleeding did not stop. Dr. Li called Dr. Abesamis, an oncologist-pediatrician, to assist in the case. When Angelica had another attack, Dr. Abesamis pumped her chest to revive her. They strapped her hands to the bed and attached instruments to her to provide her oxygen and suction blood from her stomach. She later became hysterical and tried to remove the instruments attached to her. Angelica died at 3:00 a.m. When Dr. Li came by, she said that a malfunction occurred.

When Reynaldo asked Dr. Li for a death certificate, she became arrogant, calling him names. Dr. Li even asked him to sign a promissory note as he did not have enough cash on him to settle the hospital bill.

For her part, Dr. Li testified that Dr. Tamayo referred Angelica to her after he operated on the patient. Angelica suffered from a highly malignant, highly aggressive type of cancer known as osteosarcoma. Less than 20% of patients who were operated on for this type of cancer survived the first year. It usually came back within six months. There has been no known cure for cancer as even its causes have not been ascertained.

Dr. Tamayo referred the case to Dr. Li because he found during the surgery that the cancer could have already spread from the bone to the soft tissue and the surrounding area. Dr. Tamayo asked Dr. Li if she could give Angelica adjuvant chemotherapy. When she met the Solimans, Dr. Li told them what adjuvant chemotherapy was about, why it would be given, how it would be given, and how chemotherapy works. Surgery, she told them, was not enough for, while the tumor had been removed, it left small lesions that could not be seen by the eyes. Chemotherapy would clean out the small lesions to lower the chances of the cancer recurring. Dr. Li gave no guarantee of a cure. She merely told the Solimans that, if adjuvant chemotherapy was to be given, the chances of their daughter's survival would increase and the chances of the cancer returning would lower.

Dr. Li met the Solimans following Angelica's amputation and they discussed the side-effects of chemotherapy.

Dr. Li told the Solimans that, since it could not be helped that the drugs would get into the other parts of Angelica's body, those parts could also be affected. Angelica might lose hair and experience nausea and vomiting (which may be controlled by medicines). She could become infertile or sterile. Blood elements, such as the red and white blood cells, might also be affected and so had to be monitored. She also explained to the Solimans other side-effects, including loss of appetite and darkening of skin when exposed to sunlight. The kidneys and heart could also be affected which was the reason for monitoring these organs as well.

Dr. Li met the Solimans again sometime in the first week of August at which meeting they again discussed the chemotherapy procedure and its side-effects. When Dr. Li met Lina about a week later to once more discuss the treatment, the latter wanted to be told again about the side-effects of chemotherapy. Before Angelica was admitted to the hospital, Lina called up Dr. Li at her house and they discussed the same things.

On August 18 St. Luke's hospital readmitted Angelica for the chemotherapy. On the first day, they gave her fluids to make sure that her kidney functioned well and that she was hydrated. Seeing no problem, Dr. Li started Angelica's chemotherapy on August 19.

Regarding the redness on Angelica's face, Dr. Li explained that these were rashes. To make sure, Dr. Li consulted Dr. Abesamis because the rashes could also possibly mean that the patient had systemic lupus. Regarding Angelica's convulsions or epileptic attacks, these were actually carpo-petal spasms, a twitching of a group of muscles of the hands and legs. Dr. Li checked Angelica's calcium levels, which turned out low, so she gave her supplemental calcium. Regarding the vomiting of blood, Dr. Li explained that she did not actually vomit blood but that her gums began bleeding. She just had to spit it out.

According to Dr. Li, Angelica died due to overwhelming infection which had spread throughout her body, causing multiple organ failures and platelet reduction. Dr. Li insisted that the reduction in platelet count was due to infection although she conceded on cross-examination that, theoretically, the chemotherapy could have reduced the platelets as well. Dr. Li also alleged that Angelica had a poor defense mechanism because of her cancer.

Dr. Jaime Tamayo testified for Dr. Li. He recalled treating the cancerous growth in Angelica's lower left leg. The doctor amputated the leg to remove the source of the tumor. Residual tumor cells had to be treated, however, by chemotherapy. Even before the amputation, the Solimans knew of the possibility that Angelica would have to undergo chemotherapy after surgery. The Soliman's consultation with other doctors, including the doctor who performed the biopsy and confirmed the diagnosis for osteosarcoma, made them aware of that possibility.

After the surgery, Dr. Tamayo explained to the Solimans that the amputation was not enough and that chemotherapy was needed to go after the malignant cells that might have metastasized. He told the Solimans that their daughter's condition was grave and that her chances would improve with chemotherapy. Dr. Tamayo knew that even with surgery and chemotherapy, very few patients lived beyond five years, as the mortality rate was between 80 to 90%. He did not, however, consider it necessary to tell the Solimans this.

In sum, the Solimans claim that Dr. Li informed them of only three possible side-effects of chemotherapy: falling hair, vomiting, and weakness. Dr. Li, on the other hand, testified that she was more thorough than this, apprising the Solimans of the following side-effects of chemotherapy: hair loss, nausea, vomiting, possible infertility or sterility, lowering of red and white blood cells, adverse effects on platelets, loss of appetite, darkening of the skin, and possible adverse effects on the heart and kidneys.

The question now is who to believe.

First. The burden is of course on the Solimans to prove their allegations of wrong-doing on Dr. Li's part. Quite importantly, the trial court which had the benefit of perceiving not only the witnesses' utterances but what the

movements of their eyes and mouths said, gave credence to Dr. Li's testimony over that of the Solimans. The trial court held that Dr. Li in fact explained the effects of the chemotherapy to them prior to the procedure.

Second. The Court of Appeals (CA) of course found otherwise. It believed the Solimans' version that Dr. Li warned them only of the three side effects, given that every time Angelica's condition appeared to worsen, they would seek an explanation from Dr. Li. This, said the CA, tended to show that they were unaware of the other side-effects of the treatment.

But if it were true that Dr. Li assured Lina no less than three times that her daughter would suffer only three bearable side effects, why did Lina not confront the doctor when other side effects, which caused Angelica greater pains, began to surface?

Besides, the fact that the Solimans, especially Lina, still sought explanations from Dr. Li for her daughter's new pains and distress is understandable. Lina had a clear tendency to repeatedly inquire about matters of which she had been previously informed. By her own admission, she asked Dr. Li to tell her of the side effects of chemotherapy no less than three times: a) when they first met after the amputation; b) on the phone while she discussed the rescheduling of the chemotherapy with Dr. Li; and c) when the latter came to administer dextrose to Angelica before the chemotherapy. It should not, therefore, be surprising for Lina to want to hear the doctor's explanation about those side effects even when the latter had previously done so.

What is more, it would be quite natural for parents, watching their daughter's deteriorating condition, to want to know the doctor's explanation for it. The previous explanations did not have the benefit of the real thing occurring in their sight. The Solimans needed assurances that these manifestations, now come to pass, were to be expected. In fact, when Angelica began vomiting, the first anticipated side effect, the Solimans still anxiously queried the attending medical staff the reason for it. [1]

Third. The claim that Dr. Li gave assurance that Angelica had a 95% chance of recovery after chemotherapy cannot be believed. The Solimans knew that their daughter had bone cancer. Having consulted with other doctors from four medical institutions, the Ago Medical and Educational Center in Bicol, the UERM Medical Center in Manila, the National Children's Hospital in Quezon City, and finally the St. Luke's hospital, all of whom gave the same dire opinion, it would be quite unlikely for the Solimans to accept Dr. Li's supposed assurance that their daughter had 95% chance of returning to normal health after chemotherapy. In fact, it would be most unlikely for someone of Dr. Li's expertise to make such a grossly reckless claim to a patient who actually had only a 20% chance of surviving the first year. She would literary be inviting a malpractice suit.

Fourth. At the heart of the Solimans' claim for damages is the proposition that they would not have agreed to submit their daughter to chemotherapy had they known that the side effects she faced were more than just hair loss, vomiting, and weakness. They would not have agreed if they had known that she would suffer greater distress and soon die.

But the Solimans are arguing from hindsight. The fact is that they were willing to assume huge risks on the chance that their daughter could cheat death. They did not mind that their young daughter's left leg would be amputated from above the knee for a 50% chance of preventing the spread of the cancer. There is probably no person on this planet whose family members, relatives, or close friends have not been touched by cancer. Every one knows of the travails and agonies of chemotherapy, yet it is rare indeed for a cancer patient or his relatives not to take a chance with this treatment, which had proved successful in extending the lives of some. Unfortunately for the Solimans, their daughter did not number among the successful cases.

Fifth. The Solimans accepted the risks that chemotherapy offered with full knowledge of its effects on their

daughter. It is not fair that they should blame Dr. Li for Angelica's suffering and death brought about by a disease that she did not wish upon her. Indeed, it was not Dr. Li, according to Reynaldo, who convinced him to agree to submit his daughter to chemotherapy but Dr. Tamayo. The latter explained to him the need for her daughter to undergo chemotherapy to increase the chance of containing her cancer. This consultation took place even before the Solimans met Dr. Li.

It is a mark of their insensitivity that the Solimans included as proof of the damages they suffered, the expenses they incurred for the surgical procedure performed by Dr. Tamayo, including the latter's professional fees. The amputation that Dr. Tamayo performed took place before the chemotherapy and before the Solimans met Dr. Li. The Solimans cannot be trusted to make an appropriate claim.

[1] TSN, September 19, 1994, p. 14; TSN, December 15, 1994, pp. 6-7.

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