RETHINKING THE BURDEN OF PROOF IN MEDICAL NEGLIGENCE IN ZAMBIA: A CONSTITUTIONAL AND HUMAN RIGHTS ANALYSIS

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ABSTRACT

The framework of medical negligence claims in Zambia remains heavily influenced by inherited common law doctrines, placing a demanding burden on plaintiffs to prove duty of care, breach, causation, and damage on a balance of probabilities. Although this structure seeks to shield healthcare professionals operating within resource-constrained environments, it often produces unjust outcomes for patients, particularly within the overstretched public health sector marked by understaffing, inadequate equipment, and poor recordkeeping.This article re-examines that burden through a critical analysis of *Kopa v University Teaching Hospital Board of Management*, arguing that strict evidentiary requirements disadvantage vulnerable patients facing systemic institutional failures. It situates this critique within Zambia's constitutional framework, especially Articles 8 (human dignity), 12 (right to life), and 15 (protection from inhuman treatment), as well as the African Charter on Human and Peoples' Rights, notably Articles 4 (integrity of the person), 5 (dignity), and 16 (right to health). Drawing comparative insight from South African jurisprudence, particularly the application of *res ipsa loquitur* in *Goliath v MEC for Health, Eastern Cape* and *Ntsele v MEC for Health, Gauteng*, the article demonstrates how doctrinal flexibility can address evidentiary asymmetries without undermining professional safeguards. Ultimately, it proposes recalibrating the burden of proof to harmonize medical professional protection with patient rights, fostering a fairer and more humane healthcare accountability framework in Zambia while avoiding defensive medicine or systemic strain.

Keywords: *Medical negligence, burden of proof, human rights, right to health, Res Ipsa Loquitur, African Charter.*

Introduction

There has been quiet desperation by many families in different parts of the country watching their loved ones slip away in the crowded wards of hospitals who wonder if a missed diagnosis or delayed intervention of health practitioners could have changed everything. This is not only in urban settings as even rural mothers in far flung areas travel miles for prenatal care, only to be confronted with complications from what feels like avoidable errors. Despite these occurrences, these families find the doors of justice firmly shut by the need to prove complicated medical faults with resources they do not have. These scenarios are not abstract, they are actually drawn from the fabric of real cases such as the tragic story in **Kopa v University Teaching Hospital Board of Management**,[1] where the death of an eight-year-old boy after repeated failed procedures to remove a swallowed bottle cap left his family not just bereaved but defeated in court due to overwhelming evidentiary hurdles. In Zambia, over 80% of the population depends on public healthcare and there are chronic shortages that persist in this sector as less than 2,000 doctors serve nearly 21 million people.[2] These stories point to a deeper issue, they point to a legal system that burdens patients, many of whom are among the most vulnerable, with the full weight of proving negligence in a field that is masked with extensive expertise that an average person may not contend with.

This article delves into the heart of this issue by asking the question, whether the traditional burden of proof in a medical negligence claim actually delivers justice in present-day Zambia? It addresses this question through an empathetic analysis of healthcare providers that are overworked and the patients that are underserved. The article explores the common law foundations of medical negligence while unpacking practical problems in the way these matters are resolved in Zambia currently. It reframes the debate by using the lens of constitutional protections and the regional human rights obligations that are applicable to Zambia as well. The jurisprudence of Zambia that relates to medical negligence is limited in nature as it numbers only a handful of reported cases since independence, but that in itself speaks volumes about access to justice barriers by those affected by medical negligence actions.[3] This article draws on African scholarship and comparative experiences, particularly those from South Africa, where legacies of the same colonial

[1] (SCZ No. 8 of 2007).
[2] Christopher Mbewe. The Prevalence and Reporting of Medical Errors among Medical Personnel at Kitwe Teaching Hospital. Journal of Clinical Research. Vol. 5, Issue 5: 30853, 2021.
[3] Benny Kangwa. Medical Negligence in Zambia: A Critical Analysis of the Case of Kopa v University Teaching Hospital Board of Management. Semantic Scholar, 2015.

legal heritage have evolved toward the use of inferential tools like the *res ipsa loquitur* principle, with the aim of proposing humane reforms that bridge these legal gaps without blame.[4]

This matters because health is not just a service, it is the bedrock of human dignity and is inseparably linked to survival and flourishing. In a nation still struggling to contain the alarming rates of maternal mortality that is estimated at about 213 deaths per 100,000 live births and preventable child deaths, unchecked medical lapses will result in the erosion of trust in the health care system.[5] Nnamuchi and Ortuanya, are of the view that the health crises in Africa have always originated from systemic failures that amount to the violation of human rights.[6] Therefore, this paper is an appeal and not a confrontation as it calls for compassionate evolution so as to ensure that the law reflects the realities of Zambian life.

The Legal Framework for Medical Negligence in Zambia

The law on medical negligence in Zambia when looked at can be said to be a fabric of the English common law principles that were adapted to local contexts but have not been changed since colonial times. At the core of this principle, a plaintiff must prove four elements on the balance of probabilities: a duty of care arising from the health personnel-patient relationship; there was breach of that duty by falling below the standard expected of a reasonable professional; that there was causation where the breach directly and foreseeably caused harm to the victim; actual damage was suffered.[7] On the other hand, the standard of care is determined by the Bolam test,[8] which was derived from Bolam v Friern Hospital Management Committee.[9] The principles enunciated in this case are also applied in the Zambian context.

The seminal case of Kopa v University Teaching Hospital Board of Management,[10] illustrates this point. In this matter, a bottle cap was swallowed by an eight-year-old boy and he had to undergo multiple esophagoscopies at the University Teaching Hospital. This caused complications such as the perforation of the esophagus and eventual sepsis which ultimately led to the death of the young boy. The Supreme Court in this case held that there was no breach because the testimony of the expert witness stated that all procedures performed were within the standard of practice. The

[4] Pieter Carstens and Debbie Pearmain. Foundational Principles of South African Medical Law. 1st Edition. LexisNexis, South Africa, 2011.
[5] Gabriel Yali and Selestine H. Nzala. Health Care Providers' Perspective on Barriers to Patient Safety Incident Reporting in Lusaka District. Journal of Preventive and Rehabilitative Medicine, Volume 4, No. 1: 44-45, 2022.
[6] Obiajulu Nnamuchi and Simon U. Ortuanya. The human right to health in Africa and its challenges: A Critical Analysis of Millenium Development Goal 8, African Human Rights Law Journal, 12(1), 2012.
[7] Daniele Bryden and Ian Storey. Duty of Care and Medical Negligence. Continuing Education in Anaesthesia Critical Care & Pain. Vol. 11, Iss. 4, August, 2011.
[8] This principle entails that a practitioner whose actions are in conformity with the accepted practices of a responsible body of medical opinion will be acquitted of a medical negligence claim that is brought against them.
[9] [1957] 1 WLR 582
[10] (SCZ No. 8 of 2007).

inability of the family to present expert evidence in rebuttal led to the dismissal of the entire case. This has highlighted how often the burden places an onus on plaintiffs to break the professional consensus[11] of the medical practitioners. In most circumstances, this is a daunting task for the plaintiffs, who mostly are poor or lack the necessarily resources to achieve this task.

This precedent is echoed in many earlier decided cases in Zambia since independence. In the case of **Cicuto v Davidson and Oliver**,[12] a surgical misfortune during a hernia operation led to allegations of negligence, but the court dismissed the matter for lack of proof under the Bolam principle. In this matter, the court emphasized the need for expert rebuttal before such a claim could be proved by the claimant. The same was the case in **Edna Nyasulu v Attorney General**,[13] where there was an infection that occurred after an operation due to negligent care. However, on causation evidence, the plaintiff failed to prove that the damage was caused as a result of the acts by the medical practitioners. In **Rosemary Bwalya v ZCCM, Malcom Watson Hospital and Dr Malik**,[14] the Bolam principle was reaffirmed in the case where there is a misdiagnosis by medical practitioners. In this matter, the evidentiary threshold was placed very high to an extent that those who were affected by the negligent acts failed to prove that there was indeed medical negligence on the part of the medical practitioners.

Despite the many challenges faced by the health sector that have been pointed above and the changes that have occurred in society today, more recent jurisprudence has maintained the status core on matters to do with medical negligence. In some circumstances the court does consider the existence of delays in treatment that are a constant occurrence in many public hospitals. However, they demand clear proof of foreseeability by the medical practitioners before they can be held negligent in any circumstance. There is a plethora of matters that have recently gone before the courts, such as the matter where Idah Lungu sued the Levy Mwanawasa University Teaching Hospital,[15] on allegations of maternal care negligence after a surgical bandage was left in her abdomen following a Caesarean section. She argued that the hospital failed to ensure that all surgical materials were removed, alleging a breach of section 60 of the Health Professions Act of 2009, which requires medical professionals to maintain a high standard of care. She contended that the negligence by the medical practitioners nearly cost her life. In the case of **James Phillip**

[11] Professional Consensus is a widely held agreement among qualified specialists in a specific field based on the collective interpretation of available evidence. It represents a collective judgment that is used to establish the best practices in a field. In this situation every member of the medical team confirms their stance and the team makes a decision that everyone agrees on.
[12] (1968) ZR 149 (HC)
[13] (1983) ZR 105
[14] (2005) ZMSC 1
[15] News Diggers—Woman Sues Levy Mwanawasa Hospital for Leaving Surgical gauze in her Abdomen. https://diggers.news/courts/2024/04/17/woman-sues-levy-mwanawasa-hospital-leaving-surgical-gauze-in-her-abdomen/

Mdala (Suing as Administrator of the Estate of Agnes Lucia Kaluzi Mdala) v Viva Med Limited and Others,[16] the plaintiff sued the first defendant and its associated medical practitioners for the negligence that had resulted in the death of his wife. The court held that there was no negligence on the part of the defendants as they professionally discharged their duties in accordance with the required standard of their practice.

Complementary to civil law is the Health Professions Act,[17] which provides for the regulation of practitioners through the establishment of the Health Professions Council of Zambia. The Health Professions Act in section 66 defines professional misconduct as 'improper or disgraceful conduct,' and provides that sanctions include a fine, suspension or deregistration. Despite this provision speaking to the aspect of misconduct, the law does not include what would amount to medical negligence of health practitioners.

Despite the law not pronouncing itself explicitly on what constitutes medical negligence, cases such as **Wang v Health Professionals Council of Zambia**,[18] where negligent treatment was considered misconduct have highlighted how the law partly covers disciplinary actions against medical practitioners. Despite this, civil claims that are made against medical practitioners still require independent proof to be brought to court by the claimant themselves. This Act in section 8 demands that every medical practitioner should be registered, it prohibits any health practitioner from practicing without registration. It also requires under section 65 that practitioners uphold ethical standards at all times as they conduct their work. Despite this provision, the law does not shift the burden on the practitioner in matters that are brought before the court.

Challenges with the Traditional Burden of Proof

In sum, the inflexible burden of proof in Zambian medical negligence claims does turn what ought to be a way to accountability into complexities that patients have to go through. At the heart of this issue is the question of the control of evidence which is crucial to establish breach and causation as in most cases this evidence is lost, misplaced or the medical records are solely owned by the defendants. It is observed that most public hospitals retain manual documentation and the overstretched staff consider saving lives as the thing that is more important than actually compiling the paperwork of patients.[19] This in itself has led to the continued existence of gaps in holding medical practitioners accountable for the mishaps in their work. According to Kangwa, in analyzing the Kopa case, he postulates that plaintiffs actually have the onus to request medical

[16] [2024] ZMHC 265
[17] No. 17 of 2024
[18] (2012/HK/339)
[19] See Yali and Nzala, *supra* note 5.

records through discovery of documents.[20] This is not usually a success as there are delays or denials to access such information which then adds to the trauma that they are already going through.

Another obstacle is the necessary expert testimony required under the Bolam principle. With only 1 doctor per 10,000 people in Zambia, compared with the recommendation by the World Health Organisation (WHO) of 1 per 1,000 people.[21] It can be seen that experts of a suitable calibre are scarce and expensive to pay. Additionally, the patients in rural areas face challenges such as inadequate logistics, a phenomenon that is seen to worsen inequality.

It is very difficult to establish causation in complicated situations because the "but for" test requires demonstrating that the breach was the direct cause of the damage or injury that has been suffered. However, the interrelatedness of some factors in under-resourced environments, such as equipment failure or the lack of basic supplies, makes linkages difficult to establish.[22] In maternal cases, where Zambia's negligence rates are already high, proving negligence in the midst of systemic issues is a very difficult task. The litigation rates are low as there are less than 20 reported cases post-independence because of costs to pursue such matters and also awareness gaps in those who are affected.

Empirical evidence shows that many of those that are affected either settle matters outside court or they do not pursue them at all.[23] Vulnerable groups such as women, children and the poor bear the greatest impact. It has been observed that in many cases, economic challenges act as a barrier to the pursuit of such matters further. As seen in most African settings, fears of blame by many health providers leads to a situation where there is little to no reporting of such matters, which then perpetuates even more harm to those seeking health services.[24] These challenges make justice an illusion and hence, they are contradictory to Zambia's commitment to equity as spelled out in the Constitution.

Constitutional Foundations of the Right to Health in Zambia

Although the Constitution of Zambia does not explicitly provide for a right to health and is therefore not enumerated as a justiciable right in the current bill of rights. The constitution in article

[20] See Kangwa, *supra* note 3.
[21] World Health Organization. Health Workforce in Zambia: 2023 Annual Report. https://www.who.int/countries/zmb
[22] Babafemi Odunsi. Medical Negligence and Its Litigation in Nigeria. Beijing Law Review, 2023, 14, 1090-1122.
[23] See Kangwa, *supra* note 3.
[24] Health Department of South Africa. National Policy for Patient Safety Incident Reporting and Learning in the Public Health Sector of South Africa. Technical Report. 2016: Yali and Nzala, *supra* note 5.

12 provides for the right to life as it prohibits arbitrary deprivations of the life of another person.[25] This right maybe looked at as a strong anchor for rethinking negligence burdens in Zambia so as to protect the lives of those seeking medical services. Fatal negligence, as seen in the case of Kopa v University Teaching Hospital Board of Management, clearly invokes this and in a way gives the state a duty to prevent avoidable deaths in public health facilities. The heavy burdens of proof applied by courts could be regarded as an indirect violation of the right to life because more often than not, they deny remedies to the affected parties.

The Constitution in article 8 upholds human dignity as a fundamental national value and principle and in article 15 forbids inhuman or degrading treatment.[26] Substandard health care in wards that are overcrowded and long waits before being attended to may qualify as degrading treatment especially for those patients that are vulnerable. It is trite that the principles of justice provide that there should be fair hearings and that every person must be able to have access to justice. However, it is difficult to uphold such principles as evidentiary irregularities make it hard to achieve fairness. This is because a plaintiff cannot meaningfully contest claims without being at an equal footing with the defendant.

Comparative regional constitutions support the right to health as a justiciable right as it has been explicitly embedded in the law. The Constitution of South Africa, in section 27, provides that everyone has the right to have access to health care.[27] This provision makes health rights binding and justiciable in this country. In Southern Africa, South Africa has one of the strongest provisions on the right to health, which in a way also informs cases of medical negligence. In Malawi, article 13 of the Constitution stipulates health promotion.[28] It provides that the state shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing legislation to provide adequate health care that is commensurate with the health needs of Malawian Society and international standards of health care.[29] Therefore, Zambia should interpret its provisions progressively to take advantage of such directives to inform justiciable rights with health rights. It may be contended that these provisions impose positive duties on the state to ensure accountable health care and therefore, unchecked systemic negligence can be seen to amount to violations of the constitution.

A Human Rights Perspective: Regional Obligations

[25] Moses Mulumba, et al. Constitutional Provisions for the for the Right to Health in East and Southern Africa. Centre for Health, Human Rights and Development. EQUINET Discussion Paper 81. April, 2010.
[26] The Constitution of Zambia
[27] The Constitution of South Africa.
[28] The Constitution of Malawi.
[29] Moses Mulumba, et al. Constitutional Provisions for the for the Right to Health in East and Southern Africa. Centre for Health. Policy Brief 27. EQUINET. Harare. November, 2011.

The ratification of the African Charter on Human and Peoples' Rights[30] by Zambia imposes binding duties. Article 16 of the charter mandates the "best attainable state of physical and mental health." It provides that state parties should take necessary measures to protect the health of their people and ensure that they receive medical attention when they are sick. The African Commission interprets article 16 expansively to ensure that states are held accountable for the harm that is caused to citizens. Consequently, negligence in those hospitals that are run by the state violates this provision especially where the harm that is caused to citizens is actually one that is preventable.[31]

Article 4[32] of the charter protects life and integrity as it provides that human beings are inviolable. It further provides that every human being is entitled to respect for his life and integrity. Therefore, no one may be arbitrary deprived of their life.[33] Article 7 has provisions for fair hearings. It provides that every person shall have the right to have his cause heard. It is therefore seen that heavy burdens of proof deny effective remedies for affected individuals as most times these individuals, who in most cases are the vulnerable find it difficult to prove medical negligence on the part of the medical practitioners as a result of a number of challenges. This conflicts with the provisions of the African Charter that have been stated above. As observed, these matters serve as reason to compel Zambia to re-adjust the burden of proof in matters of medical negligence so as to ensure that there is full compliance to the human rights provided in the African Charter.

Comparative Insights from Southern Africa

In the Southern African region, South Africa has similar common law roots and faces similar health strains as those faced by Zambia. Therefore, lessons may be drawn from their reforms on medical negligence. While the courts in South Africa had initially declined the application of the *res ipsa loquitur*[34] principle in medical cases in the earlier case of **Van Wyk v Lewis**,[35] in this case, the courts stated that a doctor is not liable if they follow standard accepted practices even if an injury occurs. It established the reasonable doctor test for negligence which focuses on reasonable care rather than absolute perfection. In more recent cases, the courts now apply the res ipsa loquitur principle with a lot of caution as opposed to the way it was applied in the past. The court now

[30] The African Charter, 1981.
[31] See Nnamuchi and Ortuanya, *supra* note 6.
[32] The African Charter, 1981.
[33] The African Charter, 1981.
[34] In English it is translated as the “thing speaks for itself.” This principle entails that the mere occurrence of some type of accident or injury is sufficient to imply that there is the existence of negligence.
[35] (1924) AD 438

infers negligence from those facts that are unexplained, which then shifts the burden to the defendant to show that they did not cause the injury or damage that has been suffered.[36]

In the case of **Cecilia Goliath v Member of the Executive Council for Health, Eastern Cape**,[37] the South African Supreme Court addressed the unrealistic barrier created when courts refuse to apply the doctrine of *res ipsa loquitur*. In this matter, a surgical swab was left in the patient's abdomen after a routine hysterectomy. The lower court originally dismissed the claim, as they were bound by the old precedent of *Van Wyk v Lewis*, which avoided the doctrine in medical contexts. However, the court of appeal reversed this, noting that when the procedure is under the exclusive control of medical staff and the facts are within their direct knowledge, the court should draw an inference of negligence if the defendant fails to provide a reasonable explanation.

In the case of **Lungile Ntsele v MEC for Health, Gauteng Provincial Government**,[38] the court examined the burden of proof when a child sustained permanent brain damage due to perinatal asphyxia. In contrast to the rigid Zambian standard, the court held that because of the exceptional nature of medical cases, where the patient is often unconscious or lacks technical knowledge, the plaintiff only needs to establish a prima facie case. This then casts an evidential rebuttal burden on the defendant to destroy the probability of negligence. Furthermore, Ntsele established that when clinical notes are missing or lost, it inescapably justifies an adverse inference of negligence against the hospital.

Furthermore, in the case of **Charles Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape**,[39] the South African Constitutional Court highlighted the unrealistic nature of delays in medical interventions. The court found the state liable for permanent paralysis because it failed to provide treatment within the critical four-hour window required for spinal cord injuries. This case emphasizes that the standard of care is not just about what a body of medical men think is acceptable practice, but whether a person's constitutional right to access healthcare services and timely intervention was respected.

It can be drawn from these two countries that the South African courts have developed their medical jurisprudence to ensure that it equally protects the constitutional rights of patients. However, the Zambian position tilts more towards protecting the medical practitioners and does not really carter for the patients. The law in Zambia has many exceptions that protect the medical practitioner in various instances which in a way ultimately neglects patients.

[36] See Carstens and Pearmain, *supra* note 4.
[37] [2014] ZASCA 182
[38] [2012] ZAGPJHC 208
[39] [2015] ZACC 33

Proposals for Reform

The reforms need to take a quantitative approach that aims to maintain professional confidence in the health sector. This can be done by firstly, liberalizing the *res ipsa loquitur* principle for clear cases of retained instruments which will then shift explanations to the defendant instead.

Secondly, introducing statutory presumptions in the case of missing records or the absence of consent under the Health Professions Act.

Thirdly, this shall entail compelling the timely disclosure of records to enable patients have full access to their medical records.

Fourthly, disciplinary findings of the Health Professions Council of Zambia (HPCZ) must be allowed to be considered as prima facie evidence of medical negligence under the Health Professions Act.

Fifthly, the public must be enlightenment on their rights by having campaigns on rights or awareness talks so as to align with the duties that are provided under the African Charter.

These recommendations are rooted in African insights and therefore, promote a balance between protecting the patient and ensuring that medical practitioners are protected when they adhere to standard medical practice. This balance ensures that both parties are considered as important in the handling of matters to do with medical negligence. Ultimately, such a balance will ensure that Zambian law is no longer a colonial relic, but a reflection of what is obtaining on the ground in our society today.

Conclusion

In Zambia, while protective, the burden of proof in medical negligence often times silences patients which contradicts their dignity as constitutionalized and as founded in African rights. Embracing inferences and disclosures from regional models would allow the nurturing of accountable medical care. Consequently, this evolution which will be driven by human sentiment will ensure that the law uplifts all citizens especially the most vulnerable. Thus, Zambia should rethink its burden of proof to ensure justice for all victims. By adopting a more sustainable and robust legal framework similar to that of South Africa, the Zambian courts could move away from a standard that allows medical judgment to bypass judicial scrutiny. Ultimately, this will develop the Zambian jurisprudence on medical negligence which for a long time has remained rooted in common law history.

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