Republic of the Philippines
Supreme Court
Manila

FIRST DIVISION

OUR LADY OF LOURDES HOSPITAL, Petitioner,	**G. R. No. 189218**
	Present:
- versus -	SERENO, *CJ*, Chairperson, LEONARDO-DE CASTRO, DEL CASTILLO, PERLAS-BERNABE, and CAGUIOA, *JJ.*
SPOUSES ROMEO AND REGINA CAPANZANA, Respondents.	Promulgated: MAR 2 2 2017

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DECISION

SERENO, *CJ:*

We resolve the instant Petition for Review on Certiorari[1] assailing the Decision[2] and Resolution[3] rendered by the Court of Appeals (CA), Second Division, in CA-G.R. CV No. 89030.

THE ANTECEDENT FACTS

Regina Capanzana (Regina), a 40-year-old nurse and clinical instructor pregnant with her third child, was scheduled for her third caesarean section (C-section) on 2 January 1998. However, a week earlier, on 26 December 1997, she went into active labor and was brought to petitioner hospital for an emergency C-section. She first underwent a pre-operative physical examination by Dr. Miriam Ramos[4] (Dr. Ramos) and

[1] *Rollo*, pp. 127-205.
[2] Id. at 10-40; dated 24 October 2008; penned by Associate Justice Portia Aliño-Hormachuelos and concurred in by Associate Justices Hakim S. Abdulwahid and Teresita Dy-Liacco Flores.
[3] Id. at 42-43; dated 12 August 2009; penned by Associate Justice Portia Aliño-Hormachuelos and concurred in by Associate Justices Hakim S. Abdulwahid and Fernanda Lampas-Peralta.
[4] There are references to her as Dr. Mirriam Ramos but the pleadings she submitted in this case indicate the name Dr. Miriam Ramos.

Dr. Milagros Joyce Santos,[5] (Dr. Santos) the same attending physicians in her prior childbirths. She was found fit for anesthesia after she responded negatively to questions about tuberculosis, rheumatic fever, and cardiac diseases. On that same day, she gave birth to a baby boy. When her condition stabilized, she was discharged from the recovery room and transferred to a regular hospital room.[6]

At 2:30 a.m. the following day, or 13 hours after her operation, Regina who was then under watch by her niece, Katherine L. Balad (Balad), complained of a headache, a chilly sensation, restlessness, and shortness of breath. She asked for oxygen and later became cyanotic. After undergoing an x-ray, she was found to be suffering from pulmonary edema. She was eventually transferred to the Intensive Care Unit, where she was hooked to a mechanical ventilator. The impression then was that she was showing signs of amniotic fluid embolism. [7]

On 2 January 1998, when her condition still showed no improvement, Regina was transferred to the Cardinal Santos Hospital. The doctors thereat found that she was suffering from rheumatic heart disease mitral stenosis with mild pulmonary hypertension, which contributed to the onset of fluid in her lung tissue (pulmonary edema). This development resulted in cardio-pulmonary arrest and, subsequently, brain damage. Regina lost the use of her speech, eyesight, hearing and limbs. She was discharged, still in a vegetative state, on 19 January 1998.[8]

Respondent spouses Capanzana filed a complaint for damages[9] against petitioner hospital, along with co-defendants: Dr. Miriam Ramos, an obstetrician/gynecologist; Dr. Milagros Joyce Santos, an anesthesiologist; and Jane Does, the nurses on duty stationed on the second floor of petitioner hospital on 26-27 December 1997.[10]

Respondents imputed negligence to Drs. Ramos and Santos for the latter's failure to detect the heart disease of Regina, resulting in failure not only to refer her to a cardiologist for cardiac clearance, but also to provide the appropriate medical management before, during, and after the operation. They further stated that the nurses were negligent for not having promptly given oxygen, and that the hospital was equally negligent for not making available and accessible the oxygen unit on that same hospital floor at the time.[11]

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[5] The complaint referred to her as Dr. Jocelyn Santos but she filed her Answer clarifying that she should be referred to as Dr. Milagros Joyce Santos.
[6] *Rollo*, p. 838.
[7] Id.
[8] Id.
[9] Records, vol. 1, pp. 22-29; dated 24 February 1998 and docketed as Civil Case No. MC-98-149.
[10] *Rollo*, pp. 838-839.
[11] Id.

They prayed for actual damages amounting to ₱814,645.80; compensatory damages, ₱3,416,278.40; moral damages, ₱5,000,000; exemplary damages, ₱2,000,000; attorney's fees, ₱500,000 as well as ₱5,000 per hearing and the costs of suit. They likewise prayed for other just and equitable reliefs.[12]

Petitioner hospital, defendants Dr. Ramos and Dr. Santos filed their respective Answers.[13] On the other hand, the service of summons on the nurses was unsuccessful, as they were no longer connected with the hospital. Thus, only defendant Florita Ballano (Ballano), who was later proven to be a midwife and not a nurse, filed her Answer.[14]

Petitioner hospital and defendant Ballano claimed that there was no instruction to the hospital or the staff to place Regina in a room with a standby oxygen tank. They also claimed that the nurses on duty had promptly attended to her needs. They prayed that the complaint be dismissed and respondents ordered to pay unpaid medical bills.[15]

Meanwhile, defendant Dr. Ramos claimed that in all of the consultations and prenatal check-ups of Regina in the latter's three pregnancies, she never complained nor informed the doctor of any symptom or sign of a heart problem. Before the last C-section of Regina, Dr. Ramos examined her and found no abnormal cardiac sound, murmur or sign of rheumatic heart ailment. The doctor further claimed that since the operation was an emergency, she had no time or chance to have Regina undergo any cardiac examination and secure a cardiac clearance. Moreover, Dr. Ramos claimed that the cardio-pulmonary arrest took place 14 hours after the operation, long after she had performed the operation. She prayed that judgment be rendered ordering spouses Capanzana to pay her moral damages amounting to ₱500,000; exemplary damages, ₱200,000; and attorney's fees, ₱100,000.[16]

On the other hand, defendant Dr. Santos claimed that she was the anesthesiologist in Regina's first and second childbirths via C-section. The doctor further stated that prior to the third emergency C-section, she conducted a pre-operative evaluation, and Regina showed no sign or symptom of any heart problem or abnormality in the latter's cardiovascular, respiratory, or central nervous systems. She then administered the anesthesia to Regina. She also stated that Regina's condition before, during, and after the operation was stable. Dr. Santos prayed that the complaint against her be dismissed.[17]

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[12] Id. at 293; 839.
[13] Records, vol. 1, pp. 88-93 (for Dr. Ramos), pp. 131-143 (for Dr. Santos), and pp. 156-166 (for petitioner hospital).
[14] Records, vol. 6, pp. 1624-1634.
[15] *Rollo*, pp. 839-840.
[16] Id. at 840-841.
[17] Id. at 840.

Trial ensued. Plaintiffs presented Dr. Erwin Dizon, a cardiologist; Dr. Godfrey Robeniol, a neurologist; Mrs. Elizabeth Tayag; Dr. Eleonor Lopez, a cardiologist; Kathleen Lucero Balad; Romeo Capanzana; and Dr. Asuncion Ranezes, a physician.[18]

After the plaintiffs rested their case, an amended complaint was filed, this time identifying and impleading as defendants the nurses on duty who included Czarina Ocampo, H.R. Bolatete, Evelyn S. David, and Angelica Concepcion.[19] After conducting a deposition of the person in charge of the nurses' schedule, spouses Capanzana further amended their complaint to implead nurses Rochelle Padolina and Florita Ballano, while dropping defendants Czarina Ocampo, H.R. Bolatete, and Angelica Concepcion.[20]

The trial continued with the presentation of defense evidence. The defense presented Dr. Santos; Dr. Ramos; Atty. Nicolas Lutero III, director of the Bureau of Licensing and Facilities of the Department of Health; Lourdes H. Nicolas, the assistant nursing service director; Dr. Grace de los Angeles; Ma. Selerina Cuvin, the account receivable clerk; and Milagros de Vera, the administrative supervisor of the hospital.[21]

On 11 May 2005, and pending the resolution of the case before the trial court, Regina died and was substituted by her heirs represented by Romeo Capanzana.[22]

THE RULING OF THE RTC

On 29 December 2006, the RTC rendered judgment, finding no negligence on the part of Dr. Ramos or Dr. Santos. It found that the medical community's recognized standard practices in attending to a patient in connection with a C-section had been duly observed by the doctors.[23]

The RTC also found that the primary cause of Regina's vegetative state was amniotic fluid embolism, an unfortunate condition that was not within the control of any doctor to anticipate or prevent. This condition was the root cause of the pulmonary edema that led to hypoxic encephalopathy, brain damage and, ultimately, Regina's vegetative state. On the other hand, the trial court noted that hypoxic encephalopathy was manageable. It could have been prevented, or at least minimized, had there been a timely administration of oxygen.[24]

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[18] Id. at 842.
[19] Records, vol. 3, pp. 811-819.
[20] Records, vol. 5, pp. 1508-1516.
[21] *Rollo*, pp. 847-851.
[22] Id. at 838.
[23] Id. at 852-856.
[24] Id. at 859.

On the strength of the testimony of Balad, the RTC found that negligence on the part of the nurses contributed to the injury of Regina. It found that they failed to respond immediately when Regina was experiencing shortness of breath. It took the nurses more or less 10 minutes after being informed of the condition of Regina before they checked on her, called for the resident doctor, and requested oxygen. While the trial court acknowledged that the immediate administration of oxygen was not a guarantee that Regina's condition would improve, it gave credence to the testimony of the expert witness. The latter opined that the delay contributed to the onset of hypoxic encephalopathy or diffuse brain damage due to lack of oxygen in Regina's brain. The expert witness also said that had there been a timely administration of oxygen the risk of brain damage would have been lessened, if not avoided, and the onset of hypoxic encephalopathy reduced. The RTC therefore found the nurses liable for contributory negligence.[25]

On the issue of whether petitioner hospital could be held liable for the negligence of its nurses, the RTC ruled that the hospital was able to discharge the burden of proof that it had exercised the diligence of a good father of a family in the selection and supervision of its employees. The trial court arrived at this finding on the basis of the testimony of the assistant nursing director, Lourdes Nicolas. She stated that the selection and hiring of their nurses was a rigorous process, whereby the applicants underwent a series of procedures – examination, orientation, training, on-the-job observation, and evaluation – before they were hired as regular employees. The nurses were supervised by their head nurses and the charge nurse. The nurses were also inspected by their clinical supervisor and nursing director. Consequently, only the nurses were held liable to pay damages. However, since the trial court acquired jurisdiction only over Ballano among those on duty on that day, she was the only one held liable.[26] The dispositive portion of the RTC decision states:

> WHEREFORE, all foregoing considered, judgment is rendered as follows:
>
> A. Ordering the defendant FLORITA BALLANO to pay the plaintiff Romeo R. Capanzana and the children of the spouses Capanzana, namely: Roxanne, Rizelle, and Reginald (all minors) who are represented by plaintiff Romeo R. Capanzana in respect to the children's right to the interest of their deceased mother Regina in this case:
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> 1. The amount of Pesos: Two Hundred Ninety Nine Thousand One Hundred Two and 04/100 (₱299,102.04), as and by way of actual damages;
> 2. The amount of Pesos: One Hundred Thousand (₱100,000.00), as and by way of moral damages;
> 3. The amount of Pesos: One Million Nine Hundred Fifty Thousand Two Hundred Sixty Nine and 80/100

[25] Id. at 856-857.
[26] Id. at 857-858.

(₱1,950,269.80), as and by way of compensatory damages;
4. The amount of Pesos: One Hundred Thousand (₱100,000.00), as and by way of attorney's fees;
5. The cost of suit.

B. Ordering the DISMISSAL of the case as against defendants Our Lady of Lourdes Hospital, Inc., Dr. Mirriam Ramos and Dr. Milagros Joyce (Jocelyn) Santos; and

C. DISMISSING the counterclaims of the defendants.

SO ORDERED.[27]

Respondents Capanzana filed their appeal[28] before the CA, arguing that the RTC committed error in holding that amniotic fluid embolism, which could not have been foreseen or prevented by the exercise of any degree of diligence and care by defendants, caused the cardio-pulmonary arrest, brain damage, and death of the patient (instead of rheumatic heart mitral valve stenosis which could have been detected and managed). Respondents further argued that it was error for the trial court to hold that defendants Dr. Ramos and Dr. Santos and petitioner hospital exercised due diligence and to absolve them from liability for the untimely death of Regina.[29]

Petitioner hospital also filed its notice of appeal.[30] It imputed error to the trial court for holding that the nurses had not exercised due diligence in attending to the needs of Regina, particularly because (1) respondent spouses failed to prove any breach of duty on the part of the nurses, particularly Ballano; (2) there was no delay in the delivery of oxygen to Regina; and (3) Regina was afflicted with amniotic fluid embolism, a condition that could not have been foreseen or prevented by any degree of care by defendants.[31] Also, petitioner hospital decried the dismissal of its counterclaims and the exclusion of the material testimony of one of the hospital nurses.[32]

THE RULING OF THE CA

The CA rendered the assailed decision affirming the RTC ruling with modification. The appellate court upheld the finding of the trial court that the proximate cause of Regina's condition was hypoxic encelopathy, a diffuse brain damage secondary to lack of oxygen in the brain. Specifically, the cause was hypoxic encelopathy secondary to pulmonary cardiac arrest on the

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[27] Id. at 860-861.
[28] CA *rollo*, p. 44.
[29] *Rollo*, pp. 945-1017.
[30] CA *rollo*, pp. 45-46.
[31] *Rollo*, p. 889.
[32] Id. at 757-767. A Motion for Leave dated 20 December 2004 was filed by petitioner hospital to take the deposition of a witness, nurse-on-duty defendant Evelyn David, but the Motion was denied by the trial court in an Order dated 12 April 2005.

background of pulmonary edema. The CA decreed that the failure of Dr. Ramos to diagnose the rheumatic heart disease of Regina was not the proximate cause that brought about the latter's vegetative condition as a probable or natural effect thereof. Even if the appellate court were to concede that Regina indeed suffered from rheumatic heart mitral valve stenosis, it was not established that Dr. Ramos ignored standard medical procedure and exhibited an absence of the competence and skill expected of practitioners similarly situated.[33]

The CA especially took note of the fact that when Regina was operated on for the third time, albeit in an emergency situation, she had the benefit of her complete medical history. Also, even the expert witness presented by the plaintiffs, Dr. Dizon, testified that most patients suffering from mild mitral valve stenosis are asymptomatic, so the disease cannot be detected on physical examination. He further testified that a request for cardio-pulmonary clearance is discretionary, and that a referral to a pulmonologist can be done away with if the attending physician finds the patient's heart normal. Thus, the appellate court upheld the ruling of the trial court absolving Dr. Ramos.[34]

On the issue of the liability of Dr. Santos, the CA discredited the theory of Dr. Dizon that the normal post-operation dosage of 3 liters of intravenous fluid for 24 hours, or 1 liter every 8 hours, could be fatal to a patient with a heart problem. It ruled that Dr. Dizon was presented as an expert witness on cardiology, and not on anesthesiology. Upholding the RTC, the appellate court gave more credence to the testimony of Dr. Santos, who was accepted as an expert witness in the fields of anesthesiology and obstetric anesthesiology. She had testified that even if the dosage was beyond the recommended amount, no harmful effect would have ensued if the patient's kidney were functioning properly. She examined Regina before the operation and found no edema – an indication that the latter's kidney was functioning well. The testimony of Dr. Santos remained uncontroverted. The CA also upheld the ruling that respondents similarly failed to prove that Dr. Santos had ignored standard medical procedure and exhibited an absence of the competence and skill expected of practitioners similarly situated. Consequently, the appellate court also upheld the ruling of the trial court absolving Dr. Santos.[35]

Meanwhile, the CA absolved Ballano. Like the RTC, the appellate court found evidence that the nurses were negligent. But contrary to the trial court, the CA held that there was no showing whether Ballano, who was later identified as a midwife, was negligent in attending to the needs of Regina. Further, it was not shown whether Ballano was even one of the nurses on duty who had attended to Regina. The appellate court also noted

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[33] Id. at 22-25.
[34] Id. at 25.
[35] Id. at 26-27.

that the execution of health care procedures and essential primary health care is a nurse's (not a midwife's) duty.[36]

Finally, the CA ruled that petitioner hospital should be held liable based on the doctrine of corporate responsibility. It was found that while there was evidence to prove that petitioner hospital showed diligence in its selection and hiring processes, there was no evidence to prove that it exercised the required diligence in the supervision of its nurses. Also, the appellate court ruled that the non-availability of an oxygen unit on the hospital floor, a fact that was admitted, constituted gross negligence on the part of petitioner hospital. The CA stressed that, as borne out by the records, there was only one tank in the ward section of 27 beds. It said that petitioner hospital should have devised an effective way for the staff to properly and timely respond to a need for an oxygen tank in a situation of acute distress.[37]

Accordingly, the CA awarded to respondents exactly the same amounts decreed by the RTC. This time, however, instead of Ballano, petitioner hospital was deemed directly liable to pay for those amounts.[38]

Only petitioner hospital filed a Motion for Reconsideration,[39] which the CA denied. The denial came after a finding that the errors raised in support of the motion were substantially a mere reiteration of those already passed upon and considered in the assailed decision.[40]

Hence, this petition.

Petitioner hospital is now before this Court assailing the rulings. First, it argues that the CA ruled contrary to law and evidence, because there was no proof of any breach of duty on the part of the nurses. Petitioner argues that even if there was a failure to provide oxygen, it did not cause the injury sustained by Regina. It emphasizes that she suffered from amniotic fluid embolism, a condition that could not be detected or prevented by any degree of care on the part of the hospital or its nurses. Second, it argues that it was an error for the CA to hold the former liable on the basis of the doctrine of corporate responsibility. Third, it alleges that the appellate court erroneously neglected to find respondents liable for the unpaid hospital bill. Fourth, it claims that the CA supposedly erred in upholding the exclusion of the testimony of defendant David.[41] Petitioner ultimately prays that the present petition be granted, the assailed rulings of the CA reversed and set aside, the second amended complaint dismissed, and petitioner's counterclaims granted.[42]

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[36] Id. at 34-35.
[37] Id. at 35-39.
[38] Id. at 39.
[39] Id. at 243-283.
[40] Id. at 241-242.
[41] Id. 153-154.
[42] Id. at 203.

Respondents filed their Comment,[43] saying that the CA committed no error in finding petitioner liable for the negligence of the nurses to timely administer oxygen to Regina. Neither did the appellate court, they claim, err in applying the doctrine of *res ipsa loquitur* or in decreeing that petitioner hospital had failed to exercise due diligence in the selection and supervision of the latter's nurses. They further claim that the CA was correct in holding petitioner liable under the doctrines of vicarious liability and corporate negligence. Respondents also insist that Regina did not die of amniotic fluid embolism.[44] Hence, they pray that the instant petition be denied and that the assailed ruling of the CA, which affirmed that of the RTC, be upheld.[45]

Petitioner filed its Reply.[46] It vehemently protests the idea that Regina died at its hands. It reiterates that respondents failed to prove that its purported negligent act caused the injury she sustained, and that the administration of oxygen would have prevented the brain damage she later suffered. Petitioner also disputes the ruling that the nurses were negligent in attending to her needs. It bewails the exclusion of the testimony of one of the defendant nurses who could have debunked the testimony of Balad. It restates its prayer that the present petition be granted and the assailed rulings of the CA reversed and set aside. Further, it prays that the second amended complaint be dismissed and its counterclaims granted. Additionally, albeit belatedly, it asks that the case be remanded to the trial court for the reception of the testimony of defendant nurse David.

OUR RULING

We find the petition partially meritorious.

We reiterate the elementary rule that only questions of law are entertained in a Rule 45 petition.[47] Findings of fact of the lower courts are generally conclusive and binding on this Court whose function is not to analyze or weigh the evidence all over again. While there are exceptional cases in which this Court may review findings of fact of the CA, none of these exceptions is present in the case at bar.[48] We see no compelling reason to deviate from this general rule now. We therefore defer to the pertinent factual findings of the lower courts, especially because these are well-supported by the records. It is in this light that we affirm the findings of both the trial and the appellate courts which found negligence on the part of the nurses.

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[43] Id. at 1461-1526.
[44] Id. at 1463-1525.
[45] Id. at 1525.
[46] Id. at 1544-1575.
[47] Rules of Court, Rule 45. See *Pascual v. Burgos,* G.R. No. 171722, 11 January 2016*; Lynvil Fishing Enterprises, Inc. v. Ariola*, 680 Phil. 696 (2012); *Abad v. Guimba,* 503 Phil. 321 (2005); *Collector of Customs v. CA,* 242 Phil. 26 (1988).
[48] *Rosales v. People,* G.R. No. 173988, 8 October 2014; *Castillo v. CA*, 329 Phil. 150 (1996).

In order to successfully pursue a claim in a medical negligence case, the plaintiff must prove that a health professional either failed to do something which a reasonably prudent health professional would have or have not done; and that the action or omission caused injury to the patient. Proceeding from this guideline, the plaintiff must show the following elements by a preponderance of evidence: duty of the health professional, breach of that duty, injury of the patient, and proximate causation between the breach and the injury.[49] Meanwhile, in fixing a standard by which a court may determine whether the physician properly performed the requisite duty toward the patient, expert medical testimonies from both plaintiff and defense are resorted to.[50]

In this case, the expert testimony of witness for the respondent Dr. Godfrey Robeniol, a neurosurgeon, provided that the best time to treat hypoxic encephalopathy is at the time of its occurrence; i.e., when the patient is experiencing difficulty in breathing and showing signs of cardiac arrest.[51]

To recall, the records, including petitioner's Nurses' Notes, indisputably show that Regina complained of difficulty in breathing before eventually showing signs of cyanosis.[52] We agree with the courts below in their finding that when she was gasping for breath and turning cyanotic, it was the duty of the nurses to intervene immediately by informing the resident doctor. Had they done so, proper oxygenation could have been restored and other interventions performed without wasting valuable time. That such high degree of care and responsiveness was needed cannot be overemphasized – considering that according to expert medical evidence in the records, it takes only five minutes of oxygen deprivation for irreversible brain damage to set in.[53] Indeed, the Court has emphasized that a higher degree of caution and an exacting standard of diligence in patient management and health care are required of a hospital's staff, as they deal with the lives of patients who seek urgent medical assistance.[54] It is incumbent upon nurses to take precautions or undertake steps to safeguard patients under their care from any possible injury that may arise in the course of the latter's treatment and care.[55]

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[49] *Solidum v. People,* G.R. 192123, 10 March 2014; *Flores v. Pineda,* 591 Phil. 699 (2008); *Reyes v. Sisters of Mercy Hospital*, 396 Phil. 87 (2000).

[50] *Casumpang v. Cortejo,* 752 Phil. 379 (2015); *Solidum v. People,* G.R. 192123, 10 March 2014; *Dr. Li v. Spouses Soliman,* 66 Phil. 29 (2011).

[51] *Rollo,* p. 999.

[52] Id. at 159.

[53] Id. at 856-857.

[54] *Hospital Management Services, Inc.-Medical Center Manila v. Hospital Management Services, Inc.-Medical Center Manila Employees Association-AFW*, 656 Phil. 57 (2011).

[55] Sec. 27 of Article V of Republic Act No. (R.A.) 7164 or an "Act Regulating the Practice of Nursing in the Philippines" effective on 21 November 1991 although this was later repealed by R.A. 9173 or an "Act Providing for a More Responsive Nursing Profession, Repealing for the Purpose Republic Act No. 7164" effective 21 October 2002.

The Court further notes that the immediate response of the nurses was especially imperative, since Regina herself had asked for oxygen. They should have been prompted to respond immediately when Regina herself expressed her needs, especially in that emergency situation when it was not easy to determine with certainty the cause of her breathing difficulty. Indeed, even if the patient had not asked for oxygen, the mere fact that her breathing was labored to an abnormal degree should have impelled the nurses to immediately call the doctor and to administer oxygen.

In this regard, both courts found that there was a delay in the administration of oxygen to the patient, caused by the delayed response of the nurses of petitioner hospital. They committed a breach of their duty to respond immediately to the needs of Regina, considering her precarious situation and her physical manifestations of oxygen deprivation. We quote below the crucial finding of the trial court:

> [W]hen Kathleen [Balad] went to the nurse station to inform the nurses thereat that her aunt was experiencing shortness of breathing and needed oxygen nobody rushed to answer her urgent call. It took more or less 10 minutes for these nurses to go inside the room to attend and to check the condition of their patient. When the nurse came in she saw the patient was having chilly sensation with difficulty in breathing [and was] at the same time asking for oxygen. The nurse learned from Kathleen that the patient was having an asthma attack. The nurse immediately called resident physician Dr. De Los Angeles to proceed to room 328 and the hospital aide to bring in the oxygen tank in the said room. Thereafter, resident doctors Gonzalez and de Los Angeles arrived and followed by the hospital aide with the oxygen tank. It was clear that the oxygen tank came late because the request for it from the nurses also came late. Had the nurses exercised certain degree of promptness and diligence in responding to the patient[']s call for help[,] the occurrence of "hypoxic encephalopathy" could have been avoided since lack or inadequate supply of oxygen to the brain for 5 minutes will cause damage to it. (Underscoring supplied)[56]

The CA agreed with the trial court's factual finding of delay in the administration of oxygen as competently testified to by Balad. Her testimony, which is uncontroverted in the records, proceeded as follows:

Q [Atty. Diokno]:	During this time from about 1:30 in the morning up to approximately 2:00 in the morning, did any nurse enter the room that you were in?
A [Balad]:	None, sir.
Q:	After that conversation between your aunt when she's asking you to [turn] off the aircon and turning on [sic] again and then turned it off, do you have any occasion to talk with her?
A:	None, sir.

[56] *Rollo*, pp. 20-21; 856-857.

Q: How did you describe her physical appearance when she was telling you that "hinihika yata ako"?
A: She feels [sic] very cold even if several blankets were placed in [sic] her body and she is [sic] coughing at the same time.

Q: What about during the time that you dropped some pillows at her back?
A: She was running her breath sir, "at inaalala niya ang operasyon niya."

Q: Seeing her condition like that what did you do if anything to get any help for her?
A: I buzzered, sir.

Q: About how many time[s] did you buzz for help?
A: Several times, sir, because I saw Tita Regie [Regina] as if she doesn't [sic] take it anymore, sir.

Q: How long did it take before any nurse come [sic] to the room?
A: Ten (10) to fifteen (15 minutes) because they were not in the nurse's station, sir.

x x x x

Q: What did the nurse do when she entered the room?
A: She asked me if we have an [sic] history of asthma, sir, in the family.

Q: What was your answer.
A: We have, sir, then she hold [sic] the hand of Tita Regie.

Q: What, if anything, did Tita Regie saying [sic] at that time when the nurse was inside the room?
A: She was running her breath and she was mentioning "oxygen, oxygen," sir.

Q: What happened after that?
A: The nurse went out, sir, I was holding Tita Regie at the same time I called up Tito Romy, sir.

x x x x

Q: Going back to the time when the nurse came in and asked you if your family has an [sic] history of asthma. After that and after touching the hands of Regina, what did the nurse do?
A: She went out because Tita Regie was asking for an oxygen, sir.

Q: Did the nurse say anything or give any instruction before leaving the room?
A: I cannot recall, sir, because I was already afraid of the color [cyanosis] of Tita Regie, sir.

Q: How long did it take before any oxygen arrived if ever?
A: About 20 minutes, sir.[57] (Emphases supplied)

The appellate court also correctly noted that even the witness for petitioner, resident physician Dr. Grace de los Angeles, noticed that it took some time before the oxygen arrived as shown in her testimony:

Q [Atty. Tanada]: But do you know how much time elapsed from the time oxygen was first requested since you were not yet there?

x x x x

A [Dr. Delos Angeles]: The one who first orders not considering the nurse's order, it was me who first ordered for the oxygen.

Q: A nurse made an earlier order also?
A: Yes, sir.

x x x x

Q: Do you recall having heard a statement made by any doctor to the effect why did the oxygen tank just arrive[d] at that moment?

x x x x

A: When the nurse, said 'nagpakuha na ng oxygen,' I could not recall if it is [sic] me or Dra. Gonzales, we asked her 'Bakit wala pa?'

Q: So your answer is there was somebody who made that comment?
A: Yes, Your Honor.[58] (Underscoring supplied)

The CA also found that there was negligent delay in referring Regina to the physicians.[59] In fact, a member of the medical staff chided the nurses for not immediately referring the patient's condition to the physicians as the following excerpt shows:

Q [Atty. Diokno]: Without mentioning anymore whom you believed to be the speaker. Could you just relay what were the things that you heard, said at that time.

x x x x

[57] TSN, 25 February 1999, pp. 31-36.
[58] TSN, 26 September 2003, pp. 29-30.
[59] *Rollo*, p. 34.

A [Balad]: "Why is it that the dextrose is only now, why did you not ask for assistance immediately," sir.[60] (Underscoring supplied)

The records also show another instance of negligence, such as the delay in the removal of Regina's consumed dextrose, a condition that was already causing her discomfort. In fact, Balad had to inform the nurses and the patient had to instruct one of them, on what to do as can be seen in this part of Balad's testimony:

Q [Atty. Diokno]: Would you try to recall what were the words that were used by your aunt in telling you about the dextrose?

A [Balad]: According to her you call [the] nurse at the nurse station for her to remove the dextrose from my hand, sir.

x x x x

Q: When you saw that [sic] two (2) nurses there at the nurse station, what were they doing?

A: The other one is sitting eating pansit, sir, and the other one is standing holding a bottle, sir.

Q: What did you tell them, if anything, when you arrived at the nurse station?

A: I told them that the dextrose at Room 238 was already finished, sir.

x x x x

Q: How long did it take before any nurse arrived inside Room 238?

A: I went back to the nurse station because no one responded from [sic] my call, sir.

Q: About how many minutes had elapsed from the time you went to the nurse station for the first time and from the time you went for the second time?

A: About three (3) to five (5) minutes, sir. "Yung pangalawang tawag ko na sa kanya ay nakasunod na siya sa akin," sir.

Q: The second time when the nurse was already following you back to the room. What happened there when you go [sic] inside the room?

A: The nurse approached my Tita Regie and according to my Tita Regie, "Nurse, please remove it because my hand was already bulging," sir.

Q: What is the response of the nurse to that comment of your auntie?

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[60] TSN, 25 February 1999, pp. 38-40.

A: She was following the instruction of my Tita Regie and then she told me to get a towel, sir, to be placed on her hand, "namaga na", sir.[61] (Underscoring supplied)

Taken together, the above instances of delay convinced the courts below, as well as this Court, that there was a breach of duty on the part of the hospital's nurses. The CA therefore correctly affirmed the finding of the trial court that the nurses responded late, and that Regina was already cyanotic when she was referred to the resident doctor.

Regina suffered from brain damage, particularly *hypoxic encephalopathy*, which is caused by lack of oxygen in the brain. The testimonies of Dr. Dizon and Dr. Robeniol proved this fact. And the proximate cause of the brain damage was the delay in responding to Regina's call for help and for oxygen. The trial court said:

> Had the nurses exercised certain degree of promptness and diligence in responding to the patient[']s call for help[,] the occurrence of "hypoxic encephalopathy" could have been avoided since lack or inadequate supply of oxygen to the brain for 5 minutes will cause damage to it.[62]

The CA affirmed the above ruling of the RTC, that whatever the cause of the oxygen deprivation was, its timely and efficient management would have stopped the chain of events that led to Regina's condition.

We affirm the findings of the courts below that the negligent delay on the part of the nurses was the proximate cause of the brain damage suffered by Regina. In *Ramos*, the Court defines proximate cause as follows:

> Proximate cause has been defined as that which, in natural and continuous sequence, unbroken by any efficient intervening cause, produces injury, and without which the result would not have occurred. An injury or damage is proximately caused by an act or a failure to act, whenever it appears from the evidence in the case, that the act or omission played a substantial part in bringing about or actually causing the injury or damage; and that the injury or damage was either a direct result or a reasonably probable consequence of the act or omission. It is the dominant, moving or producing cause. (Underscoring supplied; citations omitted).[63]

Thus, a failure to act may be the proximate cause if it plays a substantial part in bringing about an injury. Note also that the omission to perform a duty may also constitute the proximate cause of an injury, but only where the omission would have prevented the injury.[64] The Court also

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[61] Id. at 22-26.
[62] *Rollo*, pp. 856-857.
[63] *Ramos v. CA*, 378 Phil 1198 (1999).
[64] Cesar J. Sangco, Philippine Law on Torts and Damages, 263 (1984 rev. ed.).

emphasizes that the injury need only be a reasonably probable consequence of the failure to act. In other words, there is no need for absolute certainty that the injury is a consequence of the omission.[65]

Applying the above definition to the facts in the present case, the omission of the nurses – their failure to check on Regina and to refer her to the resident doctor and, thereafter, to immediately provide oxygen – was clearly the proximate cause that led to the brain damage suffered by the patient. As the trial court and the CA both held, had the nurses promptly responded, oxygen would have been immediately administered to her and the risk of brain damage lessened, if not avoided.

For the negligence of its nurses, petitioner is thus liable under Article 2180[66] in relation to Article 2176[67] of the Civil Code. Under Article 2180, an employer like petitioner hospital may be held liable for the negligence of its employees based on its responsibility under a relationship of *patria potestas*.[68] The liability of the employer under this provision is "direct and immediate; it is not conditioned upon a prior recourse against the negligent employee or a prior showing of the insolvency of that employee."[69] The employer may only be relieved of responsibility upon a showing that it exercised the diligence of a good father of a family in the selection and supervision of its employees. The rule is that once negligence of the employee is shown, the burden is on the employer to overcome the presumption of negligence on the latter's part by proving observance of the required diligence.[70]

In the instant case, there is no dispute that petitioner was the employer of the nurses who have been found to be negligent in the performance of their duties. This fact has never been in issue. Hence, petitioner had the burden of showing that it exercised the diligence of a good father of a family not only in the selection of the negligent nurses, but also in their supervision.

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[65] *Ramos v. CA,* 378 Phil 1198 (1999).

[66] Art. 2180. The obligation imposed by Article 2176 is demandable not only for one's own acts or omissions, but also for those of persons for whom one is responsible.

x x x x

The owners and managers of an establishment or enterprise are likewise responsible for damages caused by their employees in the service of the branches in which the latter are employed or on the occasion of their functions.

Employers shall be liable for the damages caused by their employees and household helpers acting within the scope of their assigned tasks, even though the former are not engaged in any business or industry.

x x x x

The responsibility treated of in this article shall cease when the persons herein mentioned prove that they observed all the diligence of a good father of a family to prevent damage.

[67] Art. 2176. Whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done. Such fault or negligence, if there is no pre-existing contractual relation between the parties, is called a quasi-delict and is governed by the provisions of this Chapter.

[68] *Ramos v. CA,* 378 Phil 1198 (1999).

[69] *Manliclic v. Calaunan*, 541 Phil. 617 (2007).

[70] *OMC Carriers v. Spouses Nabua*, 636 Phil. 634 (2010); *Syki v. Begasa,* 460 Phil. 381 (2003); *Metro Manila Transit Corporation v. CA*, G.R. No. 104408, 21 June 1993.

On this point, the rulings of the RTC and the CA diverge. While the trial court found due diligence in both the selection and the supervision of the nurses, the appellate court found that petitioner proved due diligence only in the selection, but not in the supervision, of the nurses.

After a careful review of the records, we find that the preponderance of evidence supports the finding of the CA that the hospital failed to discharge its burden of proving due diligence in the supervision of its nurses and is therefore liable for their negligence. It must be emphasized that even though it proved due diligence in the selection of its nurses, the hospital was able to dispose of only half the burden it must overcome.[71]

We therefore note with approval this finding of the CA:

> While Lourdes Hospital adduced evidence in the selection and hiring processes of its employees, it failed to adduce evidence showing the degree of supervision it exercised over its nurses. In neglecting to offer such proof, or proof of similar nature, respondent [herein petitioner] hospital failed to discharge its burden under the last paragraph of Article 2180. Consequently, it should be held liable for the negligence of its nurses which caused damage to Regina.[72]

Indeed, whether or not the diligence of a good father of a family has been exercised by petitioner is a matter of proof,[73] which under the circumstances in the case at bar has not been clearly established. The Court finds that there is not enough evidence on record that would overturn the presumption of negligence. In explaining its basis for saying that petitioner proved due diligence in the supervision of the nurses, the trial court merely said:

> As testified to by Ms. Lourdes Nicolas, the assistant nursing director, the process of selection and hiring of their nurses was a rigorous process whereby the applicants undergo series of examination, orientation, training, on the job observation and evaluation before they are hired as regular employees. The nurses are supervised by their head nurses and the charge nurse and inspected by their clinical supervisor and nursing director. Based from this evidence the court believes that defendant hospital had exercised prudence and diligence required of it. The nurses it employed were equipped with sufficient knowledge and instructions and are able to perform their work and familiar with the duties and responsibilities assigned to them.[74]

Indeed, the formulation of a supervisory hierarchy, company rules and regulations, and disciplinary measures upon employees in case of breach, is indispensable. However, to prove due diligence in the supervision of

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[71] *Valenzuela v. CA*, 323 Phil. 374 (1996).
[72] *Rollo*, p. 37.
[73] *Metro Manila Transit Corporation v. CA*, G.R. No. 104408, 21 June 1993.
[74] *Rollo*, p. 857.

employees, it is not enough for an employer such as petitioner to emptily invoke the existence of such a formulation. What is more important is the actual implementation and monitoring of consistent compliance with the rules. Understandably, this actual implementation and monitoring should be the constant concern of the employer, acting through dependable supervisors who should regularly report on their supervisory functions. Thus, there must be proof of diligence in the actual supervision of the employees' work.[75]

In the present case, there is no proof of actual supervision of the employees' work or actual implementation and monitoring of consistent compliance with the rules. The testimony of petitioner's Assistant Nursing Service Director, Lourdes H. Nicolas is belied by the actual records[76] of petitioner. These show that Nurses David and Padolina had been observed to be latecomers and absentees; yet they were never sanctioned by those supposedly supervising them. While the question of diligent supervision depends on the circumstances of employment,[77] we find that by the very nature of a hospital, the proper supervision of the attendance of its nurses, who are its frontline health professionals, is crucial considering that patients' conditions can change drastically in a matter of minutes. Petitioner's Employee Handbook[78] recognized exactly this as it decreed the proper procedure in availing of unavoidable absences and the commensurate penalties of verbal reprimand, written warning, suspension from work, and dismissal in instances of unexcused absence or tardiness.[79] Petitioner's failure to sanction the tardiness of the defendant nurses shows an utter lack of actual implementation and monitoring of compliance with the rules and ultimately of supervision over its nurses.

More important, on that fatal night, it was not shown who were the actual nurses on duty and who was supervising these nurses. Although Lourdes H. Nicolas explained in her testimony that two nurses are assigned at the nurses' station for each shift and that they are supervised by the head nurses or the charge nurses, the documents of petitioner show conflicting accounts of what happened on the fateful days of 26 and 27 of December 1997.

The schedule of nurses initially submitted by the director of the nursing service of petitioner hospital, Sister Estrella Crisologo, indicated that David was on duty from 2 p.m. to 11 p.m. on 26 December 1997 and that Padolina and Ballano were on duty from 10 p.m. of 26 December 1997 to 6 a.m. of 27 December 1997. Ballano, however, was employed as a midwife

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[75] *Pleyto v. Lomboy*, 476 Phil. 373 (2004). See also *Metro Manila Transit Corporation v. CA*, G.R. No. 104408, 21 June 1993.

[76] The Terminating Employee Appraisal signed by the nursing supervisor, Sister Vicencia, and noted by Sister Estrella showed defendant David as an occasional latecomer and absentee and as dishonest and insincere (Records, vol. 7, p. 2024) while the Terminating Employee Appraisal signed by the supervisor, Sister Hirene, showed defendant Padolina as a habitual latecomer and absentee (Records, vol. 7, p. 2045).

[77] *Valenzuela v. CA*, 323 Phil. 374 (1996).

[78] Records, vol. 7, p. 2022.

[79] *Rollo*, p. 646.

and not a nurse.[80] Also, the oral deposition of Sister Estrella Crisologo indicated that a certain Molina, a nurse, did not report for work from 10 p.m. of 26 December 1997 to 6 a.m. of 27 December 1997 leaving only Padolina as the nurse on duty during the said period while Evelyn David was on duty only from 2 p.m. to 11 p.m. on 26 December 1997.[81] However, in a Manifestation[82] dated 15 July 1999, petitioner submitted a revised and more accurate schedule of nurses prepared by the nurse supervisor, Charina G. Ocampo, which curiously contained erasures on the portion pertaining to Evelyn David in that David was now shown to be on duty from 10 p.m. on 26 December 1997 to 6 a.m. on 27 December 1997.[83]

Another piece of documentary evidence, the Nurses' Notes, was also not without inconsistencies. In a Manifestation and Motion[84] dated 3 June 2003, petitioner admitted to having inadvertently failed to include an entry or page in the Nurses' Notes initially submitted to the trial court.[85] That entry was the Nurse's Observation and Report on Capanzana from 8 p.m. of 26 December 1997 to 3:20 a.m. of 27 December 1997 signed by David.[86] Moreover, in the testimony of witness for petitioner, Milagros de Vera, the administrative supervisor of the hospital, it was revealed that entries in the Nurses' Notes were made in different colors of ink depending on the shift of the nurse: blue ink for the morning shift, black for afternoon, and red for night. Interestingly, as manifested by the counsel for respondents, the entries made from 2:45 to 2:50 a.m. of 27 December 1997 were in both blue and red.[87]

All these negate the due diligence on the part of the nurses, their supervisors, and ultimately, the hospital.

We therefore affirm the appellate court in finding petitioner directly liable for the negligence of its nurses under Article 2180 in relation to Article 2176 of the Civil Code.

We are left with two minor issues that need to be addressed in order to completely resolve the petition. To recall, petitioner questioned before the CA not only the trial court's denial of petitioner's Motion for Leave to take the deposition of a witness but also the denial of its counterclaims. In the assailed Decision and Resolution, the appellate court failed to make a pronouncement expressly addressing the issues. Petitioner now prays that we

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[80] In a Manifestation dated 15 May 2001, petitioner stated that Ballano was a midwife and not a nurse. (Records, vol. 6, pp. 1521-1522). In her Answer with Compulsory Counterclaims dated 11 September 2001, Ballano claimed that she was employed as a midwife. (Records, vol. 6, p. 1625)
[81] TSN, 11 December 2000, pp. 15-17.
[82] Records, vol. 2, pp 542-543.
[83] Id. at 545-547.
[84] Records, vol. 6, pp. 1847-1849.
[85] Records, vol. 3, pp. 821-842.
[86] Records, vol. 6, pp. 1851.
[87] TSN, 12 November 2004, pp. 20-21.

remand the case to the trial court for the reception of the testimony of its witness and that we grant its counterclaims.

In support of the first issue, petitioner invokes our pronouncements in *Hyatt Manufacturing Corp. v. Ley Construction Development Corp.*,[88] in which this Court affirmed the appellate court's ruling to remand the case to the trial court and to order the deposition-taking to proceed. To bring this issue to a close, we see the need to present a nuanced parsing of the difference between the circumstances in *Hyatt* and in the present petition. *First*, in the cited case, the party opposing the deposition made unwarranted claims of delay. This Court found that it was not the request for deposition, but the voluminous pleadings filed by the opposing party, that caused the delay in the court proceedings. In this case, however, there is reason to suspect that the request was indeed meant to delay because the intended deposition in 2004 was meant to be an additional sur-rebuttal evidence to Balad's testimony which, we characteristically take note, was given in 1999, a long five years before. Moreover, the trial court reasoned that the case had been tried for many years and was about to be decided:

> The timeliness of the motion for leave of court to take deposition through written interrogatories cast doubt whether or not it was intended to further delay the proceedings of this case. The instant case has obtained considerable length in its adjudication and to allow movant-defendants to take deposition of Ms. David [the witness-deponent] would only further delay its disposition and would certainly defeat the purpose of a disposition which is to expedite proceedings.[89]

Second, in *Hyatt*, the trial court arbitrarily cancelled the taking of depositions, which had been scheduled previously. In other words, everything had been set, and the deponents were available for deposition. Delay, if any, would have been minimal. In the present case, no deposition was ever scheduled, and the availability of the supposed deponent was not even ascertained. In fact, the uncertainty in the taking of the deposition was one of the reasons cited by the trial court when it denied the Motion for Leave.[90]

Third, the RTC in this case noted that petitioner had agreed to a self-imposed deadline for the submission of its sur-rebuttal evidence. When the scheduled hearing came, petitioner's counsel failed to attend purportedly because he was indisposed. But as curiously observed by the trial court, the reception of sur-rebuttal evidence on that date could not have proceeded anyway since petitioner had no witnesses.[91] The trial court likewise noted that petitioner failed to state any solid ground to justify the grant of the

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[88] 519 Phil. 272 (2006).
[89] *Rollo*, p. 769.
[90] Id. at 768.
[91] Id. at 768-769.

taking of that deposition, except for the latter's naked assertion that the witness to be deposed was out of the country.[92] The Court finds that these considerations, taken together, provided one of the reasons for the RTC to properly deny the Motion for Leave to take the deposition of a witness. In *Hyatt*, the movant was completely faultless; in the present case, petitioner failed not only to be present at the scheduled hearing for the submission of its sur-rebuttal evidence, but also to show good faith in its request.

Fourth, the movant in *Hyatt* was clearly prejudiced by the denial of its request, which it had promptly made before pretrial. The same cannot be said in the present case because petitioner filed the motion to take deposition six years after trial had started. In fact, petitioner was confident enough to agree to a deadline for the submission of its sur-rebuttal evidence, a deadline that had long passed when it filed a Motion for Leave. Petitioner is, therefore, estopped from claiming that it was ever prejudiced.

All in all, petitioner's argument regarding the trial court's denial of petitioner's Motion for Leave to take the deposition fails to impress us.

This notwithstanding, we find merit in another argument successively raised by petitioner before the Court of Appeals and before this Court with respect to the unpaid hospital bill of respondents – an issue not addressed again by the CA in the assailed ruling. The unpaid hospital bill at petitioner hospital amounted to ₱20,141.60 as of 30 October 1998.[93] This fact was uncontroverted by respondents. Since the amount for actual damages as listed by respondents in their complaint was already inclusive of the hospital bills incurred at petitioner hospital and at Cardinal Santos Hospital, we deem it proper to deduct the unpaid hospital bill from the actual damages decreed by the lower court and affirmed by the appellate court. However, we additionally impose the payment of interest on the resulting amount to conform with prevailing jurisprudence.[94]

WHEREFORE, premises considered, we **AFFIRM WITH MODIFICATION** the Decision and Resolution rendered by the Court of Appeals in CA-G.R. CV No. 89030 in that petitioner is hereby declared liable for the payment to respondents of the total amount of ₱299,102.04 as actual damages minus ₱20,141.60 representing the unpaid hospital bill as of 30 October 1998; ₱1,950,269.80 as compensatory damages; ₱100,000.00 as moral damages; ₱100,000.00 as and by way of attorney's fees; and the costs of suit, as well as interest at the rate of six percent (6%) *per annum* on the resulting amount from the finality of this judgment until full payment.

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[92] Id. at 769.
[93] Id. at 922.
[94] *Nacar v. Gallery Frames*, G.R. No. 189871, 13 August 2013, 703 SCRA 439, 456-459.

SO ORDERED.

MARIA LOURDES P. A. SERENO
Chief Justice, Chairperson

WE CONCUR:

TERESITA J. LEONARDO-DE CASTRO
Associate Justice

MARIANO C. DEL CASTILLO
Associate Justice

ESTELA M. PERLAS-BERNABE
Associate Justice

ALFREDO BENJAMIN S. CAGUIOA
Associate Justice

CERTIFICATION

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

MARIA LOURDES P. A. SERENO
Chief Justice