EXTERNAL DEFENCE

Ph.D THESIS

ON

TORTUOUS LIABILITY OF MEDICAL PRACTITIONERS IN NIGERIA:
AN APPRAISAL

BY

ONYEGBULE, KELECHI GOODLUCK

20/Ph.D/13226

BEING A THESIS PRESENTED TO THE SCHOOL OF POSTGRADUATE STUDIES, FACULTY OF LAW, IMO STATE UNIVERITY IN PARTIAL FULFILMENT FOR THE AWARD OF DEGREE OF DOCTOR OF PHILOSOPHY (Ph.D) IN LAW, IMO STATE UNIVERSITY, OWERRI.

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APRIL, 2023

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DECLARATION

I, ONYEGBULE KELECHI GOODLUCK, a Postgraduate Student of Faculty of Law with Matriculation Number 20/Ph.D/13226 do hereby declare on my honor, that this thesis has not been previously presented, either wholly or in part for the award of any other Degree, Diploma, Certificate or Publication in any University, other Higher Institutions or elsewhere. This thesis was written by me under the strict and meticulous supervision of Assoc. Prof. Maurice Obasi and Dr. C. J. Amaechi.

…… ……

Onyegbule, Kelechi Goodluck **Date**

20/Ph.D/13226

CERTIFICATION

ONYEGBULE KELECHI GOODLUCK, a postgraduate Student of Faculty of Law with Matriculation Number 20/Ph.D/13226 has satisfactorily completed the requirements for the award of the Degree of Master of Laws. To the best of our knowledge, the work embodied in this dissertation is original and has not been submitted in part or full for any other Degree, Diploma, Certification or Publication of this University or elsewhere.

Assoc. Prof. Maurice Obasi	**……**	**……..**
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APPROVAL

We, the undersigned hereby approve this thesis submitted by Onyegbule, Kelechi Goodluck to the Faculty of Law in partial fulfillment of the requirement for the award of Degree of Doctor of Philosophy in Law (Ph.D) of Imo State University, Owerri.

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DEDICATION

This thesis is dedicated to God Almighty.

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LIST OF ABBREVIATIONS

AIDS - Acquired Immune Deficiency Syndrome

CFRN- Constitution of the Federal Republic of Nigeria

CPA- Consumer Protection Act

CTCVG - Compulsory Treatment and Care for Victims of Gunshots Act

DPS - Directors of Pharmaceutical Services

FCCPC - Federal Competition and Consumer Protection Council

FCT - Federal Capital Territory

HIV - Human Immune Virus

LFN - Laws of the Federation

MDAs - Ministries, Departments and Agencies

MDCN- Medical Dental Council of Nigeria

MDPA- Medical and Dental Practitioners Act

MDPC - Medical and Dental Practitioners Council

MDPCME - Medical andDental Practitioners Code of Medical Ethics

MDPDT- Medical & Dental Practitioners Disciplinary Tribunal

MOH- Ministry of Health

NAFDAC - National Agency for Food Drug Administration Council

NCDRC - National Consumer Disputes Redressed Commission

NHA- National Health Act

NMA- Nigerian Medical Association

NMCN - The Nursing and Midwifery Council of Nigeria

PBoR - Patients Bill of Right

PCN- Pharmacists Council of Nigeria

PIC- Pharmaceutical Inspection Committee

PPMVL- Patent and Proprietary Medicine Vendors Licence

PPP- Public Private Partnership

WACA - West African Court of Appeal

ABRSTRACT

Medical practice usually involves different activities which if not professionally handled, may give rise to liabilities on the part of the medical practitioner. These liabilities may arise in tortuous claims and in some other cases, may go beyond the realm of civil liabilities to criminal liabilities. Medical Law is an area of law that seems alien and unexplored in Nigerian jurisprudence as there is scarcely an awareness mechanism put in place in educating people as well as the medical and health practitioners on the legal implication of their actions and inactions in the course of carrying out their professional duties. This thesis therefore offered an appraisal of the tortuous liability of Medical Practitioners in Nigeria. First, it started with an introductory chapter that considered the background to the study and set out the Statement of the problems, aim and the objectives, scope, significance, limitations of the study and the research methodology. Secondly, it considered the positivist, naturalist, and realist theories considering these theories to have influenced the thesis and succinctly discussed certain concepts that constitute the conceptual frameworks for a better understanding of the paper. Thirdly, it examined the legal and institutional frameworks strengthening legal practice in Nigeria vis-à-vis negligence and liabilities of the medical practitioners in Tort. Fourthly, it appraised the various actions and inactions culminating to tortuous and criminal liability by medical and health practitioners, remedies available to victims of the negligence of the medical and health practitioners as well as the defenses available for medical and health practitioners. Fifthly, it provided a comparative analysis of tortuous liability of medical practitioners in Nigeria, the United Kingdom, Saudi Arabia and South Africa. The reason for the choice of these jurisdictions for comparative study is informed by their records of excellence in their respective healthcare industries. Lastly, it summarized with conclusion and recommends amongst others, improved awareness for the victims to approach the courts to seek redress, trainings for hospital managements on law of torts, improved surgical facilities for hospitals and adequate funding for the health institutions in Nigeria et cetera, for a reformed medical practice especially in dealing with medical negligence in Nigeria. The research methodology adopted in this thesis is doctrinal method of research.

CHAPTER ONE

1.1 BACKGROUND TO THE STUDY

Medical practice usually involves varied actions which when not checked or handled professionally may give rise to liabilities on the part of the medical practitioner. These liabilities may arise in tort, and in some cases lie in criminal actions[1].

Medical Negligence is hinged on the tortuous principle of negligence espoused by *Lord Atkin* in the notorious case of *Donoghue v Stevenson*[2]. Also known as the 'snail in the bottle case', it is a significant case in Western law. The ruling in this case established the civil law tort of negligence and obliged businesses to observe a duty of care towards their customers.

The events of the case took place in Paisley, Scotland in 1928. While attending a store, Ms May Donoghue was given a bottle of ginger beer, purchased for her by a friend. The bottle was later discovered to contain a decomposing snail. Since the bottle was not made of clear glass, Donoghue consumed most of its contents before she became aware of the snail. She later fell ill and a physician diagnosed her with gastroenteritis.

Donoghue subsequently took legal action against Mr David Stevenson, the manufacturer of the ginger beer. She lodged a writ in the Court of Sessions, Scotland's highest civil court, seeking £500 damages. Donoghue could not sue Stevenson for breach of contract because she had not purchased the drink herself. Instead, Donoghue's lawyers claimed that Stevenson had breached a duty of care to his consumers and caused injury through negligence. At the time, this area of civil law was largely untested. Stevenson's lawyers challenged Donoghue's

[1] O.A. Adejumo and O.A. Adejumo, *Legal Perspectives on liability for Medical Negligence and Malpractices in Nigeria"*, The Pan African Journal, www.ncbi.com, accessed 02/01/2022

[2] *(1982) AC, 562.*

action on the basis that no precedents existed for such a claim. They referred to an earlier action by Donoghue's lawyer, *Mullen v AG Barr*, where a dead mouse was found in a bottle of soft drink; judges dismissed this action due to a lack of precedent.[3]

Donoghue's initial action failed but she was granted leave to appeal to the House of Lords (which, at the time, had the judicial authority to hear appellate cases). The leading judgment, delivered by *Lord Atkin* in 1932, established that Stevenson was responsible for the well-being of individuals who consumed his products, given that they could not be inspected.

The case was returned to the original court. Stevenson died before the case was finalized and Donoghue was awarded a reduced amount of damages from his estate.

Medical negligence constitutes an act or omission by a medical practitioner which falls below the accepted standard of care resulting to injury or death to the patient.[4] The above case law authority establishes a general duty to take reasonable care to avoid foreseeable injury to another. Therefore, to establish a case under negligence, it must be shown that a duty of care is owed; there was a breach of such duty of care; and that damage or injury resulted from the breach of that duty.[5]

A duty of care is necessarily implied when a patient is registered and treated in any hospital.[6] It has been expressed that, the duty of care for medical practitioners ought not to be limited only to patients under their direct management but should extend to any patient whom they

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3 . M. Forde, 'Case Study: *Donoghue v Stevenson (1932)*' <https://lawgovpol.com/case-study-donoghue-v-stevenson-1932/> accessed 01/10/2022

4 F.N. Chukwuneke, *'Medical incidents in Developing Countries: A few case studies from Nigeria',* Niger J Clin Pract. 2015. [Google Scholar] accessed on 02/01/2022

5 *Ibid.*

6 O. A Adejumo , "*Legal Perspectives on liability for medical negligence and malpractices in Nigeria*", The Pan African Journal, www.ncbi.com, accessed 02/01/2022

come across or in contact with in their professional environment. As such, medical practitioners owe a duty of care to every patient found within the hospital premises, whether or not such patient is under the direct management of such medical practitioner.[7]

The view as expressed above appears extreme. However the fact is that where safely adopted, it could minimize incidents of direct or vicarious liability, on the part of the medical practitioner and the health care institution. The society will become better for it.

Flowing from the aforesaid however, in Nigeria, there is very little awareness that medical professional duties carry legal implications. The conduct of medical practitioners, positive or negative, does not only affect their employers but impact directly on third parties. Consequently, liability will arise both against the employer and the employee professional, in the event of a breach of duty by the latter to act with reasonable care and diligence. The Law is, therefore, well settled that medical practitioners owe a duty in tort, i.e., civil wrong to their patients, whether there is a contract with the patient or not.

Unfortunately, this aspect of the law is not properly developed or again properly explored in Nigeria especially in the Northern part of Nigeria, due to low level of awareness and cultural norms in which every mishap is attributable to God's will.[8] Secondly, the cost of litigation is high and even with the undeveloped Legal Aid system in Nigeria, not everybody is eligible for legal aid.

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7 D. Bryden and I. Storey, '*Duty of Care and Medical Negligence*', Continuing Education in Anaesthesia Critical Care and Pain, BJA Education, 2011. [Google Scholar] accessed 02/01/2022

8 *Ibid*

Doctor - patients relationship; evidence has shown that family doctors are less-likely to be sued as they are more likely to have a relationship of trust with their patients.[9] Nevertheless the law on medical malpractice has come to stay in Nigeria even though litigation is on a small scale. Victims of medical malpractice have brought actions against medical practitioners in Negligence, in Criminal Law, and in trespass in Nigerian courts, especially in Southern Nigeria.

These two circumstances present an ideal situation for the realization of the objectives envisaged by this research.

1.2 STATEMENT OF THE PROBLEM

Medical law is still considered one of the gray areas of law that are yet to be given attention. This is however not so in developed areas of the world but definitely not any different from the Nigerian jurisprudence. However, no matter how novel it is considered in Nigeria, there have been efforts in recent times to explore this area of law and develop same by jurists, researchers and scholars.

There is a worrisome attitude of victims of negligent acts of medical practitioners in Nigeria which attitude is largely informed by lack of awareness, formal education, exposure, and cost of litigation in Nigeria. These, among others contribute heavily in the lackluster attitude of victims resulting in the dearth of cases experienced in our courts in this regard.

Again, it is the view of this study that not all wrongs committed by a medical practitioner can successfully give rise to a claim in negligence and liability on the part of the medical

[9] . F. E. Chipiza 'Impact of Doctor-Patient Relationship' https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4732308/ accessed 14/02/2022

practitioner. This is evidently problematic as the standard of proof required to establish the tripartite requirements of negligence is a burdensome one which the victim must discharge.

Furthermore, proof of actual damage by a victim is *sine qua non* to maintaining an action in tort for medical negligence. It is not in all cases that a person may be able to prove that he suffered actual damage, even though some wrong had been done to him in the course of treatment.

The plea of *res ipsa loquitor*, which indicates clearly that the plaintiff situation was a consequence of the defendant's negligence, may not be sufficient in medical negligence cases to shift the burden of proof from the victim to the medical practitioner. This is because of the complex nature of medical practice.

It is however pertinent to observe that under the Nigerian criminal jurisprudence, no distinction was made between cases of recklessness and cases of criminal negligence arising from sheer ignorance or wanton incompetence.

Consequently, in appraising the tortuous liability of medical practitioners in Nigeria, there are problems associated with this subject of discuss. This study therefore identifies a number of questions begging for answer. They are to wit:

1. To what extent do the Nigerian legislations take care of cases of medical negligence amongst medical practitioners in Nigeria?
2. In what ways would the Nigerian courts contribute to the development and growth of medical law and practice in Nigeria nay medical negligence of medical practitioners in the course of carrying out their duties?

3. Is the burdensome nature of proving actual damage by a victim in an action in tort for medical negligence a militating factor against the development of the law of tort for medical negligence in Nigeria?
4. What are the main challenges inhibiting the development of the law of tort for medical negligence in Nigeria?
5. Are the comparative differences between Nigeria and other jurisdictions of the world in their respective jurisprudence as it concerns medical negligence and what steps should Nigeria take in measuring up with other jurisdictions?
6. How sufficient is the awareness so far created on the rights of healthcare recipients or patients in event of medical malpractice or negligent acts of medical practitioners and also on the side of healthcare providers, the need to be exposed to the liabilities arising from their negligent actions in the course of carrying out their duties?

1.3 AIM AND OBJECTIVES OF THE STUDY

As a general aim, this work undertakes an appraisal of the tortuous liability of medical practitioners in Nigeria while it seeks to raise the consciousness and awareness on the legal implication of the negligent acts of medical practitioners in the course of carrying out their professional duties and to educate people on the need to seek redress in the court of law and the available remedies.

To achieve the overall aim stated above, this research seeks to focus on the following specific objectives:

1. To appraise the legal regime guiding and regulating medical practice and conduct of medical practitioners in Nigeria in relation to medical negligence.

2. To identify and explain the practical ways the Nigerian courts can help in contributing to the growth and development of medical law and checkmating the activities of medical practitioners with the view to curbing medical negligence of medical practitioners in Nigeria.
3. To examine the burden of proof by a victim of the tort of medical negligence and determine the extent the burden of proof has discouraged the development of the law in the regard discussed in this thesis.
4. To identify and examine the challenges inhibiting the growth and development of the law of tort for medical negligence in Nigeria.
5. To draw a comparative analysis of the civil *cum* criminal liabilities of medical practitioners in Nigeria with some other jurisdictions of the world, with the sole purpose of borrowing and adopting lessons, where shown as appropriate, for Nigeria.
6. To create awareness not only on the part of health care providers at all levels, that they must have a clear appreciation of the basic legal responsibilities of their jobs but also, on the part of health care recipients that they have a right of redress in law against any health care provider who perpetrates professional malpractice on them. The activities of medical professionals, positive or negative, do not only affect their employers vicariously, and themselves, but impact on third parties. Consequently, liability will arise both against the employer and the employee professional, in the event of breach of duty by the latter to act with reasonable care and diligence.

The tortuous liabilities of medical practitioners in Nigeria will be discussed based on negligence and trespass. This of course will depend on the act or omission leading to the injury. To achieve this objective, there shall be a detailed analysis of the necessary

applicable statutory laws, restatement of legal rules and analysis of cases in both the Nigerian and other jurisdictions where the principles of law are similar. It is hoped that at the end of this research there will be rise in awareness and literacy level and therefore there will certainly be rise in litigation and the like on medical cases in Nigeria.

1.4 SCOPE OF THE STUDY

Geographically, the thesis will cover the Federal Republic of Nigeria. The thesis shall cover the laws relating to medical practice in Nigeria during and after colonization, up to the present date, especially, the law of torts.

The legal coverage of this work captures the inherent problems of medical malpractice in Nigeria, that is, the legal responsibilities of the healthcare institutions and the rights of their respective patients.

It is considered pertinent however, to establish that this area of the law is still largely undeveloped because of illiteracy and lack of awareness on the part of health care providers and the recipients alike, as well as religious beliefs on the part of most victims of medical malpractice, especially from the Northern part of Nigeria. In order to make a considerable impact with respect to this research work on the tortuous liability of medical practitioners in Nigeria, there is need for proper analysis of the available literature and cases, restatement of legal rules and recommendations for reforms in this area.

Beyond Nigeria, this thesis shall as well consider jurisdictions such as the United States of America, the United Kingdom, and Canada for comparative analysis.

1.5 SIGNIFICANCE OF THE STUDY

The importance and significance of this thesis cannot be overemphasized in the present existence of man. In the face of heightened fear as to the level of medical malpractices and negligent acts of healthcare providers arising from a number of causes, this thesis is considered a useful research and document in contributing to the curbing and/or nipping in the bud of the activities of healthcare providers and in charging up healthcare recipients to stand tall at all times.

Consequently, the significance of this thesis is made evident in the following ways;

1. There is a significant increase in knowledge about the poor and inefficient state of enforcement of civil claims arising from medical negligence, recklessness, and malpractice.
2. This study x-rays and identifies the weakness which attends the existing legal and institutional framework for medical practice in Nigeria.
3. This study is a product, in a single jacket, of an integrated chronicle of the problems of medical practitioners in Nigeria, and the difficulties they face in the field while making conscious effort at meeting their professional demands. Most of such difficulties are caused by the leadership of the country.
4. This study provides alternative causes of action through which a claim may be brought successfully against a medical practitioner for malpractice and errors.
5. This study provides alternative compensation and redress scheme which will relief patients from the hurdles of litigation in cases of medical malpractice and/or errors.

6. This work attempts a comparative study of the Nigerian situation on the subject matter, with other jurisdiction, while pointing out areas for improvement.

7. This work makes recommendations based on the findings encountered in the course of research, all leading toward bettering the existing laws and practice of medical professionals in Nigeria, and finding ways at curbing incidents of medical malpractice.

1.6 RESEARCH METHODOLOGY:

This dissertation adopts the doctrinal methodology. The primary and secondary sources were relied on in this research. The primary sources resorted to in the course of this research are, Statutes, International Instruments and Case Laws. The secondary sources are textbooks, law reports, journal articles, internet sources, interviews, newspapers, newspaper articles and personal observations of the researcher. The approaches adopted are narrative, analytical and critical approaches.

1.7 LIMITATION OF THE STUDY

An acute problem to be faced by the Author is that of authorities, especially Nigerian decided cases, which are very few. The reasons for the paucity of Nigerian cases in this regard are that; there is apprehension, probably by the courts, that many successful actions may lead to medical malpractice crises, leading to defensive medicine. Defensive medicine is medicine practiced not for the benefit of the patient, but to protect the doctor from litigation, such as, rise in number of caesarean section births as opposed to natural births.

Cost of litigation is high. In Nigeria, poverty rate is very high. Most of the victims of medical malpractice are poor people who cannot engage the services counsel to argue their briefs or

even pay court charges. Although some Lawyers in Nigeria accept to work on a contingent fee system, not all patients are able to identify them.

A contingent fee arrangement is a one where the lawyer undertakes to handle a brief without any prior payment of fee by the client, if the client at the end of the litigation receives nothing, the lawyer receives no fee, but in a successful case, the lawyer receives an agreed percentage of the damage.

However, since the general principles of law governing tortuous liability of medical practitioners all over the Common Law world are similar, decided cases from other Common Law countries will be employed. It is to be noted that, wherever reference is to be made to such cases or authorities, they must reflect directly on a similar point to be discussed or explained or illustrated under tortuous liability of medical practitioners in Nigeria. Reference shall also be made to other legal systems whenever the need so arises.

There is also the problem of lack of funds to sustain trips in order to source materials, from within and outside jurisdiction, and even to gain access to pertinent data from regulatory bodies for medical practice in Nigeria. This, to a reasonable extent, impacted on the volume of available data.

Consequently, the limitations noted above could not discourage or stop the continuation of this research work.

CHAPTER TWO
LITERATURE REVIEW

2.1 Theoretical Framework

This thesis is anchored on three theories of law, to wit: Positive Law Theory, Natural Law Theory and the Realist Theory of Law. They are discussed below.

2.1.1 Positive Law Theory

Positive laws, otherwise known as legal positivism are human-made laws that specify an action.[10] This is the theory of law that describes the establishment of specific rights for an individual or group. Etymologically, the name derives from the verb *to posit*.[11]

The concept of positive law is distinct from natural law, which comprises inherent rights, conferred not by act of legislation but by God, nature, or reason.[12] Positive law is also described as the law that applies at a certain time (present or past) and at a certain place, consisting of statutory law, and case law as far as it is binding. More specifically, positive law may be characterized as law actually and specifically enacted or adopted by proper authority for the government of an organized society.[13]

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10. K. Hans, *General Theory of Law And State*, The Lawbook Exchange, 2007, pg 362
11. Wikipedia <https://en.wikipedia.org/wiki/Positive_law#cite_note-FOOTNOTEKelsen2007392-1> accessed 14/02/2022
12. *Ibid*
13. K. Hans, *General Theory of Law And State*, The Lawbook Exchange, 2007, pg 363

Positive theory of Law is the thesis that the existence and content of law depends on social facts and not on its merits.[14] The existence of law is one thing; its merit and demerit another. Whether it be or be not is one enquiry; whether it be or be not conformable to an assumed standard, is a different enquiry[15]. The major proponents of this theory are John Austin,[16] Jeremy Bentham,[17] H.L.A. Hart,[18] among others.

The term 'positivism' has many meanings, which were tabulated by Professor Hart[19] as follows:

1. Laws are commands: - This meaning is associated with the two founders of British positivism, Bentham and his disciple Austin.
2. The analysis of legal concepts is (a) worth pursuing, (b) distinct from sociological and historical inquiries, (c) distinct from critical evaluation.
3. Decisions can be deduced logically from predetermined rules without recourse to social aims, policy or morality.
4. Moral judgments cannot be established or defended by rational argument, evidence or proof.
5. The law as it is actually laid down.

The positivist thesis does not say that law's merits are unintelligible, unimportant, or peripheral to the philosophy of law. It says that they do not determine whether laws or legal

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14 K. Allen, *Legal Positivism,* Westminster Publication, 2017, 12

15. J. Austin, *The Province of Jurisprudence Determined*, London, 1832, Chapter 10, pg 322

16. *Ibid*

17. W. Anderson, Positive Law: Thomas Hobbes, Jeremy Bentham, John Austin, <https://schoolworkhelper.net/positive-law-thomas-hobbes-jeremy-bentham-john-austin/> accessed 14/02/2022

18 H.L.A. Hart, *Concept of Law*, Claredon Law Series, 196, pg 219

19 *Ibid*

systems exist.[20] Whether a society has a legal system depends on the presence of certain structures of governance, not on the extent to which it satisfies ideals of justice, democracy, or the rule of law. What laws are in force in that system depends on what social standards its officials recognize as authoritative, for example, legislative enactments, judicial decisions, or social customs. The fact that a policy would be just, wise, efficient, or prudent is never sufficient reason for thinking that it is actually the law, and the fact that it is unjust, unwise, inefficient or imprudent is never sufficient reason for doubting it. According to positivism, law is a matter of what has been posited (ordered, decided, practiced, tolerated, et cetera.).[21]

For Bentham and Austin,[22] law is a phenomenon of societies with a *sovereign:* a determinate person or group who has supreme and absolute *de facto* power. They are obeyed by all or most others but do not themselves similarly obey anyone else. The laws in that society are a subset of the sovereign's *commands:* general orders that apply to classes of actions and people and that are backed up by threat of force or sanction. This imperatival theory is positivist, for it identifies the existence of law with patterns of command and obedience that can be ascertained without considering whether the sovereign has a moral right to rule or whether their commands are meritorious.[23]

Hans Kelsen[24] on his view, law is characterized by a *singular form and basic norm*. The form of every law is that of a conditional order, directed at the courts, to apply sanctions if a certain behavior is performed. On this view, law is an indirect system of guidance: it does not tell subjects what to do; it tells *officials* what to do to its subjects under certain conditions.

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20. F. Williams, *Legal Theories: Positive Law*, Claret Pub, 2013, 45
21. John Austin, *The Province of Jurisprudence Determined*, London, 1832, Chapter 10, pg 325
22. Law Teacher, *The Law is Made to Govern People, < https://www.lawteacher.net/free-law-essays/civil-law/the-law-is-made-to-govern-people.php> accessed 18/03/2022*
23. *Ibid*
24. K. Hans, *General Theory of Law And State*, The Lawbook Exchange, 2007, pg 368

Thus, what we ordinarily regard as the legal duty not to steal is for Kelsen merely a logical correlate of the primary norm which stipulates a sanction for stealing.[25]

Kelsen's most important contribution lies in his attack on reductivism and his doctrine of the basic norm.[26] *Nnabue*[27] posits that *Kelsen's* contribution to the development of law is considered outstanding and most remarkable of the empirical theorists. Though Bentham and Austin laid the foundation for the propagation of legal positivism, *Kelsen's* contributions are said to have advanced the theory and taken it to an enviable status.[28] He maintains that law is a normative domain and must be understood as such. Might does not make right not even legal right so the philosophy of law must explain the fact that law imposes obligations on its subjects. Moreover, law is a normative *system*; Law is not, as it is sometimes said, a rule. It is a set of rules having the kind of unity we understand by a system. For the imperativalists, the unity of a legal system consists in the fact that all its laws are commanded by one sovereign.[29] For *Kelsen*, it consists in the fact that they are all links in one chain of authority. For example, a by-law is legally valid because it is created by a corporation lawfully exercising the powers conferred on it by the legislature, which confers those powers in a manner provided by the constitution, which was itself created in a way provided by an earlier constitution.[30] The condition for interpreting any legal norm as binding is that the first constitution is validated by the following "basic norm:" *"the original constitution is to be obeyed.* Now, the basic norm cannot be a legal norm we cannot explain the bindingness of

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25. *Ibid*
26. H. Kelson, *The Pure Theory of Law,* California, University of California , 1967, pg 16
27. U.S.F. Nnabue, *Understanding Jurisprudence and Legal Theory,* Bon Publications, Owerri, Revised Ed., pg 145
28. *Ibid*
29. Stanford Encyclopedia of Philosophy, < https://plato.stanford.edu/entries/legal-positivism/> accessed on 17/02/2022.
30. *Ibid*

law by reference to more law without an infinite regress. It follows, then, that a legal system must consist of norms all the way down. It bottoms in a hypothetical, transcendental norm that is the condition of the intelligibility of any (and all) other norms as binding. To "presuppose" this basic norm is not to endorse it as good or just—presupposition is a cognitive stance only—but it is, Kelsen thinks, the necessary precondition for a non-reductivist account of law as a normative system. It should be noted that Kelsen (as modern Positivist) shares in the need to disabuse one's mind from the endless or "meaningless" saga generally referred to as "law as it is" and "law as it ought to be". In his 'Pure Theory of Law; he insists that a theory of law must be free from ethics, politics, sociology, history etc. He insists that the pure theory of law is a theory of Positive law, not of a specific order, not an interpretation but it offers a theory of interpretation. The pure theory of law is a theory of positive law, it is called pure theory because it only describes the law and attempts to eliminate from the object of this description everything that is not strictly law.[31]

There are many difficulties with this, not least of which is the fact that if we are going to accept the basic norm as the solution it is not clear what we thought was the problem in the first place[32]. One cannot say both that presupposing the basic norm is what validates all inferior norms and also that an inferior norm is part of the legal system only if it is connected by a chain of validity to the basic norm. We need a way into the circle. Moreover, it draws the boundaries of legal systems incorrectly.

If law cannot ultimately be grounded in force, or in a presupposed norm, on what does its authority rest? The most influential solution is perhaps H.L.A. Hart's. His solution resembles

[31] . H. Kelsen, *The Pure Theory of Law*, California, Massachusetts, University of California Press, 1967, 21.

[32] . J. Austin, *The Province of Jurisprudence Determined*, Cambridge, Cambridge University Press, 1995, 14

Kelsen's in its emphasis on the normative foundations of legal systems, but Hart rejects Kelsen's transcendentalist, Kantian view of authority in favor of an empirical, *Weberian* one. For Hart, the authority of law is social. The ultimate criterion of validity in a legal system is neither a legal norm nor a presupposed norm, but a social rule that exists only because it is actually *practiced,* that is, used to guide conduct. Law ultimately rests on custom: customs about who shall have the authority to decide disputes, what they shall treat as binding reasons for decision, i.e., as sources of law, and how laws may be changed. Of these three "secondary rules", as Hart calls them, the source-determining *rule of recognition* is most important, for it specifies the ultimate criteria of validity in the legal system. It exists only because it is practiced by officials, and it is not only that the recognition rule best explains their practice, it is the rule to which they actually appeal in arguments about what standards they are bound to apply. Thus for Hart too the legal system is rule-based all the way down, but at its root is a social norm that has the kind of normative force that customs have. It is a regularity of behavior regarding which officials take "the internal point of view:" they use it as a standard for guiding and evaluating their own and others' behavior, and this use is displayed in their conduct and speech, including the resort to various forms of social pressure to support the rule and the ready application of normative terms such as "duty" and "obligation" when invoking it.

The positivist theory of law has been criticized on numerous grounds. First, not all laws are couched as commands. For example, the provision contained in Chapter II of the 1999 Constitution of the Federal Republic Of Nigeria (as amended) which deals with the Fundamental Objectives and Directive Principles of State Policy is not binding on the

government of the Nation.[33] The provisions of Chapter Two of the Constitution are not justiciable and as a result, not capable of being enforced, which makes the provision not to be a command.[34]

Again, *Nnabue*[35] submits that Austin has been criticized for using the word "command" in his theory. According to the learned scholar, "command ordinarily implies an instructive statement by one human person in contemplation of a specific conduct within the confines of a state law". He argued that if a law emanates from the legislature or from an ever-changing multitude which comprise the state political machinery, it becomes difficult to ascribe such command to one commander. The learned Professor of Law finally queried: "however, if law is a command of one illimitable sovereign, how come that law continues to be in force even after the death of the so called sovereign commander"?[36]

It is submitted [37] that another criticism of positive theory of law is that it is only concerned with the sovereign enacting laws. It is not concerned with whether or not the law is moral or acceptable to the society. Again, the idea of a "commander" who has no legal limitations would not be applicable in today's world. *Per Kayode*, "even if it is a military regime, the military is still bound by the provisions of the laws".[38]

Finally, not all human beings obey the law because of the sanctions attached to it. Some people just don't contravene the law because it is their nature. For example, some people

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33 . *Section 13 to 24 of the Constitution of the Federal Republic of Nigeria, 1999 (as amended)*

34 . *Section 6(6)(c) of the Constitution of the Federal Republic of Nigeria, 1999 (as amended)*

35. U. S.F. Nnabue, *Understanding Jurisprudence and Legal Theory*, Owerri, Bon Publication, 2016, 141-142

36 . *Ibid*

37. K. Fusser, *Farewell to Legal Positivism: The Separation Thesis Unraveling*, New York City,Clarendon Press, 119-162.

38. *The Military Governor of Lagos State v. Chief Chukwuemeka Odumegwu Ojukwu (1986) I NWLR, pt 16, 621.*

abstain from murder not just because of its punishment but because they find the killing of a fellow human being repulsive.[39]

Consequently, having considered the various proponents of this school of thought and applying this theory to this thesis, it is pertinent to note that for an advancement in medical law in Nigeria and more particularly the tort for medical negligence, there must be laws or statutes codifying things that should be done and things that should not be done, the violation of which attracts the prescribed penalty. It is important that they are posited with sanctions and not left without sanctions. It behooves the Parliament therefore, whether at the National Assembly or the State House of Assembly to make laws guiding the actions of medical practitioners, and medical practice generally in Nigeria. This responsibility is constitutionally guaranteed.[40] This is the offshoot of the command theory, that sovereign refers to a person or a group of persons demanding obedience in the State, while sanction is the penalty that follows violation of the rule. Bentham, like Austin, postulated that laws in the society are a subset of the sovereign's commands of general orders that apply to classes of actions and people and that are backed up by threat of force or sanction.

2.1.2 Natural Law Theory

Natural Law Theory is a philosophical and legal belief that all humans are governed by basic innate laws, or laws of nature, which are separate and distinct from laws which are legislated.[41] Legislated laws are sometimes referred to as "positive laws" in the framework of natural law theory, to make a clear distinction between natural and social laws. This theory has heavily influenced the laws and governments of many nations, including England and the

[39]. R. Dwokin, *Taking Right Seriously*, Buston, Harvard University Press, 1978, 132.
[40]. *Section 4 of the Constitution of the Federal Republic of Nigeria, 1999 (as amended)*
[41]. H. Kayode, *Law and Legal Theories,* Freeman Publishers, Ado-Ekiti, 2017, pg 77

United States, and it is also reflected in publications like the Universal Declaration of Human Rights.[42]

Nnabue posits that the baseline of all natural law theories in that there exists some objectively ascertainable set of principles of nature according to which all things including man ought to behave.[43] He asserts the natural law theory carries with it a requirement that its principles are universal, unchangeable and absolute.

There is no unanimity about the definition and exact meaning of natural law and the term "natural law theory" has been interpreted differently at different times depending on the needs of the developing legal thought. But the greatest attribute of the natural law theory is its adaptability to meet new challenges of the transient society[44].

The natural law philosophy has occupied an important place in the realm of politics, law, religion and ethics for the earliest times. It has played the role of harmonizing, synthesizing and promoting peace and justice in different periods and protected public against injustice, tyranny and misrule.[45]

Commending the function of natural law in liberating people from politico-legal disorder and tracing its evolution, Blackstone observed, that 'the natural law being co-existent with mankind and emanating from God Himself is superior to all other laws.[46] It is binding over all the countries at all the times and no man made law will be valid if it is contrary to the law of nature'.

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42. M. McMahon, *What is Natural Law Theory,< https://www.languagehumanities.org/what-is-natural-law-theory.htm> accessed on 07/03/2022*
43. U.S.F Nnabue, Understanding Jurisprudence and Legal Theory, Bon Publishers, Owerri, 2009, p.58
44. *Ibid*
45. N. V. Paranjape, *Studies in Jurisprudence Legal Theory,* Central Law Theory, 2004, pg 95
46. W. Blackstone, *Of the Nature of Laws in General*, https://www.nlnrac.org/node/244 accessed on 09/03/2022

The natural law theory reflects a perpetual quest for absolute justice. Thus, it should not be misconceived that natural law has a mere theoretical significance. Its practical value is a historical fact as it generated a wave of liberalism and individual freedom and inspired people to revolt against totalitarian rule in France.[47]

Freedman[48] states that the history of natural law is a tale of the search of mankind for absolute justice and its failure. Therefore, with the changes in social and political conditions, the notions about natural law have also been changing. Thus, natural law has acted as a catalyst for bringing about transformation of the old prevailing legal system. It brought about a change in the old Roman law of Justinian period. The greatest contribution of natural law theory to the legal system is ideology of a universal order governing all men and the inalienable rights of the individual[49].

Natural law in common sense means the law that is largely unwritten and consists of principles of "ought" as revealed by the nature of man or reason or derived from God, etcetera. The Italian jurist, Del Vecchio[50] aptly defines the legal ideas of natural law. He observes, "natural law is the criterion which permits us to evaluate positive law and to measure its intrinsic justice". In fact, according to him, "natural law" term is analogous to band-stand with which a number of high ideals are mixed up. These are labeled as morality, justice, ethics, right reason, good conduct, equality, liberty, freedom, social justice, democracy, etcetera.

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47. M. Singh, *Theory of Natural Law,* <http://www.legalservicesindia.com/article/2105/Greek-Theory-of-NaturalLaw.html#:~:text=For%20Plato%2C%20justice%20is%20a,have%20given%20it%20to%20mankind. > accessed 14/03/2022
48. M. Freedman*, Legal Theory*, MANN Publishers, Lancashire, 2002, 97
49. *Ibid*
50. G. Del Vecchio, *General Principles of Law'* Indiana Law Journal https://www.repository.law.indiana.edu/cgi/viewcontent.cgi?article=2883&context=ilj> accessed 17/04/2022

Natural law is not a body of actual enacted or interpreted laws enforced by courts. It is rather as Ernest Baker remarks, "a way of looking at things, a spirit of 'human interpretation' in the mind of the judge and jurists". Even the contemporary sociological thinkers and realists have looked at natural law in terms of prevailing ideas about social justice "balancing of conflicting interests".[51]

According to *Cohen*[52], natural law is not a body of actual enacted or interpreted law enforced by courts; it is in fact a way of looking at things and a humanistic approach of judges and jurists1. It embodies within it a host of ideals such as morality justice, reason, good conduct, freedom, equality, liberty, and ethics and so on. From the jurisprudential point of view, natural law means those rules and principles which are supposed to have originated from some supreme source other than any political or worldly authority. Some thinkers believe that these rules have a divine origin; some find their source in nature while others hold that they are the product of reason. Even the modern sociological jurists and realists have taken recourse to natural law to support their sociological ideology and the concept of law as a means to reconcile the conflicting interests of individuals in the society.[53]

Natural law theory has been interpreted differently at different times depending on the needs of the developing legal thought. But the greatest attribute of the natural law theory is its adaptability to meet new challenges of the transient society.[54] The exponents of natural law philosophy conceive that it is a law which is inherent in the nature of man and is independent of convention, legislation or any other institutional devices.

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51. E. Barker, *Natural Law and Theory of Law,* The Cambridge Law Journal, University of Cambridge, 2009 Vol.2,
52. C. Cohen, *Readings in Jurisprudence and Legal Philosophy*, Revised Ed., 2004, p.660
53. *Ibid*
54. Y. Dalvi, *Natural Law Theories and Law in Medieval Period,* < http://www.grkarelawlibrary.yolasite.com/resources/LLM-LT-1-Yamini.pdf> 17/04/2022

Natural law comprises rules which so necessarily agree with the nature and state of man that, without observing their maxims, the peace and happiness of society can never be preserved. They are called natural laws because a knowledge of them may be attained merely by the light of reason, from the act of their essential agreeableness with the constitution of human nature: while, on the contrary, positive or revealed laws are not founded upon the general constitution of human nature but only upon the will of God: though in other respects such law is established upon very good reason and procures the advantage of those to whom it is silent[55]

The theory of natural law was known to the ancient Greeks but then elaborated by many philosophers. Some important philosophers who played a role in the development of natural law include Aristotle, Plato, and Thomas Aquinas. These legal thinkers have expressed on divergent views regarding the extent of natural law which are examined hereinafter.

Thomas Aquinas on Natural Law

Among the theologians of the medieval period, the name of Thomas Aquinas deserves a special mention. He is considered to be the representative of the natural law theory of his age.[56] In his view, social organization and state are natural phenomenon. St. Aquinas pointed out that man can control his own destiny to a considerable extent but he is subject to certain basic impulses such as impulse of self-preservation, reproduction of his species, bringing up children etcetera, for improving his future and attainment of perfection. He defined law as "an ordinance of reason for the common good made by him who has the care of the community and promulgated through reason." He maintained that, "the primary precept of

[55] Quoted in L.B. Curzon, Jurisprudence 37 (London: Cavendish Publishing Ltd, 2nd Edition, 1995).

[56] . Y. Dalvi, *Natural Law Theories and Law in Medieval Period,* < http://www.grkarelawlibrary.yolasite.com/resources/LLM-LT-1-Yamini.pdf> 17/04/2022

law is that good should be done and pursued and an evil be avoided". Man's activities are directed to ensure his survival, continuity and perfection. He must do things to achieve them and doing anything against these ends shall be morally wrong.[57]

St. Thomas Aquinas gave a fourfold classification of laws, to wit:

1. Law of God or external law;
2. Natural law which is revealed through "reason",
3. Divine law or the law of Scriptures; and
4. Human laws which we now called 'Positive law'.

Like his predecessors, St. Aquinas agreed that natural law emanate from 'reason' and is applied by human beings to govern their affairs and relations. He opined that positive law should be accepted only to the extent to which it is compatible with natural law or external law. He regarded Church as the authority to interpret divine law.[58] Thus, his approach to natural law was empirical because his conclusions were drawn from the study of human nature. He considered 'reason' as the sole repository of social life of man. He supported property rights and upheld acquisition of property by man as he derives satisfaction from it which is helpful in maintenance of peace and order in the society. He, however, held that use and enjoyment of property should not be confined only to the person acquiring it but it should extend for the common benefit of all the members of the society. Thus, primacy of natural law was the fundamental starting point of the legal philosophy of St. Thomas Acquinas. Acquinas followed Aristotelian concept of justice and held that "justice is a habit"

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57. *Ibid*
58. Y. Dalvi, *Natural Law Theories and Law in Medieval Period,* < http://www.grkarelawlibrary.yolasite.com/resources/LLM-LT-1-Yamini.pdf> 17/04/2022

formed through action and experience. He emphasized on distributive concept of justice and held that justice is a virtue which one has in relationship with others. Justice lies in the perpetual and constant desire to render to each one his right. In other words, the concept of justice carries with it, respect for the rights of others. It is a complete virtue that produces good of the individual as well as the society. The political object of justice is to keep individuals together according to Greek traditions. Justice implies equality.[59]

Socrates on Natural Law Theory

The name of Socrates occupies a prominent place among the Stoic philosophers of the ancient time. He was a great admirer of truth and moral values. He argued that like natural physical law, there is a natural moral law.[60] It is because of the 'human insight' that a man has the capacity to distinguish between good and bad is able to appreciate the moral values. Thus according to Socrates, virtue is knowledge' and whatever is not virtuous is sin'. To him, justice may be of two kinds, namely, (1) natural justice; and (2) legal justice. The rules of natural justice are uniformly applicable to all the places but the notion of legal justice may differ from place to place depending upon the existing with time and place. The reasonability of a particular law is judged by human insight and only those laws would be deemed proper which are in accordance with the principles of law of nature and are supported by human reasoning. However, Socrates did not deny the authority of the positive law but he pleaded for the necessity of natural law for security and stability of the community.[61]

[59]. *Ibid*
[60]. A. Yinka, *Law and Legal Theories,* Norman Publishers, Lagos, 2018, p54
[61]. *Ibid*

Aristotle on Natural Law Theory

Aristotle's association with natural law may be due to the interpretation given to his works by Thomas Aquinas. But whether Aquinas correctly read Aristotle is a disputed question. According to this interpretation, Aquinas's influence was such as to affect a number of early translations of these passages in an unfortunate manner, though more recent translations render them more literally.[62] Aristotle notes that natural justice is a species of political justice, viz. the scheme of distributive and corrective justice that would be established under the best political community; were this to take the form of law, this could be called a natural law, though Aristotle does not discuss this and suggests in the Politics that the best regime may not rule by law at all. The best evidence of Aristotle's having thought there was a natural law comes from the Rhetoric, where Aristotle notes that, aside from the "particular" laws that each people has set up for itself, there is a "common" law that is according to nature. Universal law is the law of Nature. For there really is, as everyone to some extent divines, a natural justice and injustice that is binding on all men, even on those who have no association or covenant with each other.[63]

Some critics believe that the context of this remark suggests only that Aristotle advised that it could be rhetorically advantageous to appeal to such a law, especially when the "particular" law of one's own city was averse to the case being made, not that there actually was such a law; Moreover, they claim that Aristotle considered two of the three candidates for a universally valid, natural law provided in this passage to be wrong. Aristotle's theoretical paternity of the natural law tradition is consequently disputed.

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62 . A. Ademola, *Law of Jurisprudence,* Hern Prints, Ado- Ekiti State, 2017, p.67

63 . *Ibid*

Thomas Hobbes on Natural Law

According to Cooper in his thesis,[64] Thomas Hobbes's moral and civil philosophy sits squarely within the Aristotelian-Thomistic tradition of natural law theorizing. Far from providing a modern, secularly-grounded civil philosophy, Hobbes's system depends on men acknowledging the existence of a single supreme God who creates human nature with an overriding purpose that provides an objective standard of value and principal reason for action, and who governs humans to realize their telos through threats of punishment for the violation of a set of literal laws promulgated to them through their natural reason.[65] Hobbes's theory thus satisfies what Cooper identifies as the two central requirements for a traditional natural law theory: the positing of an unchanging (and knowable) human nature that determines a human good, and the insistence that the requirements to pursue that telos and all necessary means to it "have a legal character".

Thomas Hobbes' good and common way of thinking sits decisively inside the Aristotelian-Thomistic custom of characteristic law guessing. A long way from giving an advanced, commonly grounded common way of thinking, Hobbes' framework relies upon men's recognizing the presence of a solitary incomparable God who makes human instinct with a superseding reason that gives a target standard of significant worth and chief explanation behind activity, and who oversees people to understand their telos through dangers of discipline for the infringement of a bunch of exacting laws declared to them through their regular explanation.[66]

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64. K. W. Cooper, *Thomas Hobbes and the Natural Law*, **University of Notre Dame Press, 2018, 331p**
65. *Ibid*
66. Soumil, *Natural Law Theory by Thomas Hobbes,* < https://www.legalserviceindia.com/legal/article-4097-natural-law-theory-by-thomas-hobbes.html> accessed 14/04/2022

Nnabue posits that Hobbes emphasized on the need to balance the claim of law of nature with the needs of state policy.[67] He states that Hobbes accused the life of a man in a state of nature of being solitary, poor, nasty, brutish and short. In other words, the life of a man was full of fear and selfishness. Nnabue asserts that Hobbe's experience of the civil war in England really opened the horizon of his thought; and enhanced his conviction on the great importance of state authority, coupled with the need to vest such authority or power in an absolute ruler.[68]

Natural law has been the basis for an array of liberation struggles. It was invoked by the Americans in their struggle of liberation from Britain, by the French during their revolution, in the abolition of slave trade and is now being used to justify what is "right, just and fair". In recognition of this theory, the 1999 Constitution of the Federal Republic of Nigeria (as amended) in Chapter IV of the said constitution dwells on Fundamental Rights.[69]

Consequently, in the realm of medical law and tortuous liability of medical practitioners, this theory is germane as the right to good medicare is innate for every being. Every human is a neighbor to another, especially ones he/she comes in contact with. Just as Gratian published in his Decretum, it is the nature of man to know what is right and therefore lawful and what is wrong and therefore unlawful,[70] it is consequently an expectation available to all persons that it is right and lawful for medical practitioners and health providers to be careful in avoidance of negligence in the course of carrying out their professional duties.

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67. U.S.F. Nnabue, *Understanding Jurisprudence and Legal Theory,* Bon Publications, Owerri, 2009, p 32
68. *Ibid*
69. *Section 33(1) of the 1990 Constitution of the Federal Republic of Nigeria (as amended)*.
70. U.S.F. Nnabue, *Understanding Jurisprudence and Legal Theory,* Bon Publishers, Owerri, 2009, p.59

2.1.3 Realist Law Theory

Legal realism was arguably the most important and controversial theory of judging in the history. And in general as well, there were few intellectual developments in law that have been as influential, controversial, and misunderstood. Its influence went far beyond as a theory of adjudication. It is said that even contemporary legal positivism owes much of its renewal to legal realism.[71]

Realism is a diverse school of thought and any attempt to homogenize it will distort more than simplify. When it comes to judicial decision-making, realists had two general thesis[72]. The birth of legal realism is largely credited to the jurist who probably would not consider himself a realist – Oliver Wendell Holmes, Jr. Holmes famously wrote that "the life of law has not been logic; it has been experience[73]. Holmes essentially argued that changes in law (at least judge-made law) were not due to logic or pre-existing law; instead, policy preferences or personal experiences of judges mattered more. Holmes also famously stated in his dissenting opinion that "general propositions do not decide concrete cases"[74]. Many commentators consider this statement as his realist position that general rules of law will never decide actual cases.

Like Holmes, Cardozo was not only an outspoken legal commentator but also a prominent judge. His main treatise published in 1921. The Nature of the Judicial Process shows that most of his views rather moderate. He observed that in most cases, there are clear legal principles, which dictate the outcome. Yet, often a clear legal answer does not exist; in such

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71 . A. Yinka, *Law and Legal Theories,* Norman Publishers, Lagos, 2018, p98

72 Schauer, F. *Thinking Like a Lawyer: A New Introduction to Legal Reasoning*, Cambridge, Harvard University Press, 2009, p. 138.

73 O. W. Holmes, Jr. *The Common Law.* New York, Dover Publications, [1881] 1991, p. 1. In his later years, while on the bench of the US Supreme Court, he also remarked that "a page of history is worth a volume of logic". *New York Trust Co. v. Eisner*, 256 U.S. 345, 349 (1921)

74 *Lochner v. New York, 198 U.S. 45, 76 (1905)* (Holmes, J., dissenting).

cases, Cardozo thought, the judge should promote social ends; and here, Cardozo admitted, a judge may be tempted to substitute his view for that of the community[75].

Roscoe Pound, like Holmes, scorned the strict reliance on logic, legal rules, and scientific law which is characterized by certainty and reason. He thought that such notions of law are responsible for fixed conceptions where premises become stiff. Like Holmes, he argued that courts should develop law by relying on public policy preferences. Already in his notable 1908 article, he assaulted the notion of "mechanical jurisprudence" (and it was he who coined that term in the same article)[76]. In his address to the American Bar Association in 1906, Pound disdained mechanical application of legal rules: "The most important and most constant cause of dissatisfaction with all law at all times it be found in the necessarily mechanical operation of legal rules[77]. So for Pound, in addition to legal rules, policy reasons and techniques for deriving doctrines play equally important role[78].

Karl Llewellyn was arguably the most influential realist. He also presented the version of legal realism that perhaps could lay claim for an established theory of law and judging. Like other realists, Llewellyn scoffed at the idea that judging is a rule bound activity, where a judge proceeds downward from legal rules to the outcome of the case: "with a decision already made, the judge has sifted through these 'facts' again, and picked a few which he puts forward as essential and whose legal bearing he then proceeds to expound"[79].

This theory considers law as the pronouncement of the judges over legal controversies brought before the court. In the words of W.E Rumble, "Judges are de-facto sovereign and they hold the position of supremacy in determining what in final analysis becomes the law

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[75]. B. Cardozo, *The Nature of the Judicial Process*. New Haven: Yale University Press, 1921, p. 136–37, 170.
[76]. R. Pound, *Mechanical Jurisprudence.* Columbia Law Review. 1908, 8: 605
[77]. R. Pound, *Address to the American Bar Association*. American Law Review. 1906, 40: 729.
[78]. R. Pound, *The Theory of Judicial Decision.* Harvard Law Review. 1923, 36: 945–946.
[79]. Llewellyn, *K. The Bramble Bush: On Our Law and Its Study*. New York: Oceana, 1930, p. 38

within a given legal system".[80] According to the words of Oliver Wendell Holmes who is one of the leading proponents of the American legal realism, "Prediction is the distinctive name of law, the prophesies of what the court would do, in fact and nothing more pretentious are what I mean by law". This school believes that the judges possess superior dominion and jurisdiction when it comes to law making as against the powers of the legislators and as a result of this, the writer will rely on the judges pronouncements in cases bordering on fair hearing in Nigeria.

On the generality of the above, it is apt to remark that the realist school of thought is principally hinged on the pronouncements and judgments of the court of law. The Realists see law as what the court says on a matter and nothing beyond same. It is therefore safe to posit that the *ratio decidenti* articulated by Lord Atkin in *Donoghue v Stevenson* is the position of the law. He stated that:

> " a manufacturer of products, which he sells in such a form as to show that he intends them to reach the ultimate consumer in the form in which they left him with no reasonable possibility of intermediate examination, and with the knowledge that the absence of reasonable care in the preparation or putting up of the products will result in an injury to the consumer's life or property, owes a duty to the consumer to take reasonable care."[81]

The realist school has a direct nexus with this thesis in the sense that the law on negligence is defined through the position and pronouncement of the court which by extrapolation applies to medical practitioners and health care givers who ordinarily owe their patients duty of care.

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80. *Ibid*
81. *Donoghue v Stevenson (1932) A C 562 HL*

2.2 Conceptual Framework

Under the Conceptual Framework, regard shall be had on discussing some key concepts that are germane to this research work. They include Negligence, Medical Negligence, Tort, Tortuous Liability, Civil Liability, Criminal Liability, Medical Practitioner, Vicarious Liability, Duty of Care, and Medical Ethics,

2.2.1 Negligence.

In medical treatment, negligence is no different in law from negligence in any other discipline. The standards and procedures are the same, whether for liability, for causation or for compensation. The term negligence may be used in numerous ways. Negligence may connote carelessness but this is not a legal connotation. This is because it cannot be acknowledged as the precise and suitable meaning of the term negligence since what is negligence in common parlance may fall short of negligence at law.

In law, negligence and duty go together. The two are correlatives to one another. Lord Baron Alderson[82] said Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do or doing something which a prudent and reasonable man would not do. This definition raises question as to reasonable man and test to determine a person as reasonable man. It cannot be regarded as a detailed meaning in terms of law as the concept of the duty of care was not mentioned. This is for the obvious reason that mere negligence in itself does not give a cause of action and to give a cause of action, the negligence must be one which amounts to a breach of duty towards the person claiming negligence.

[82] . *Blyth v Birmingham Waterworks Company (1956) 11 Exch. 781.*

There are two different opinions which clarify or deal with the term negligence. Firstly, it argues that negligence commonly suggests total or partial inadvertence of the wrong doer towards his conduct or outcome of his conduct[83]. In this context, negligence excludes or disregards intention. This means that there is no intention for the consequences. Therefore, undesired outcome are the yardsticks to differentiate negligence from intention. This implies that negligence as a tort is the breach of legal duty to take care which results in damages, undesired by the defendant to the plaintiff. This is usually tied to the inadvertence of the wrongdoer. That is, the wrongdoer does not deliberately cause the injury and never aims at bringing about the anticipated consequences but nevertheless exposes others to the risk of it. Therefore, the distinction can be drawn between negligence and intention. That is, negligence is a type of conduct, not a state of mind, not a fault or moral blameworthiness[84].

Accordingly, when one uses the expression negligence, it suggests lack of intention to cause the harm complained of[85]. It is not a mere conduct, but it is an unreasonable conduct as to the consequences of one's act[86]. Also, JS Colyer[87] points out that the term negligence may be used in two ways. Firstly, it is the name of a tort where the hurt brings an action against the wrong-doer for damages. Secondly, negligence itself is a sometime element of other torts. By this, negligence is a tort as well as a concept of the law of torts.

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83. J.A Jolowiz, E.T. Lewis and D.M Harris, *Winfield on Tort*, 9th Edition, London: Sweet and Maxwell 1971, p 205
84. *Working Ton Dock and Harbour Board v SS Towerfield (Owners)* (*1951) AC 112, 160.* See
85. *Radcliffe Vs Barnard (1870) LR 6 Ch. 654; Dixon Vs. Muckleston (1872) LR 8 ch. 155; R Vs Senior, (1899) I QB 283.*
86. I. Ramas, *The Law of Torts*, 7th Ed., Limited Bombay, 1975, p. 332
87. J.S Colyer, *A Modern View of the Law of Torts*, 1st Ed., Pergamon Press, London, 1966 p. 36

Austin and Salmond[88] contend that negligence is a state of mind, not a conduct. By this, negligence is seen as a mental condition which should be punished by damages. Austin categorizes different states of mind as needless, rashness or careless. However, critics criticize the Austin's understanding of negligence as criminalist type of negligence. To the critic, the different states of mind have no locus in the contemporary law of torts which takes into account only the external conduct of wrongdoer[89]. Therefore, negligence in the proper sense denotes a conduct rather than mental attitude.

As a form of conduct, negligence presumes the existence of a duty of care. The idea of negligence and duty are correlative. Thus, if negligence were a mental attitude, it would be difficult to identify the existence of duty. On this note, the court has emphasized the idea of duty on the part of the wrong-doer. A person is not negligent if he owes no duty towards someone[90].

In the case of *Donoghue vs. Stevenson*, (1932) AC 562 *Lord Atkin* said that, "a man cannot be charged with negligence if he has no obligation to exercise diligence". A mere fact that a man is injured by another's act does not give rise to cause of action. The issue of negligence will not arise unless there is duty to exercise care[91]. From the above, the development of two theories i.e. mental theory and conduct theory is noticeable. **Salmond** who is an advocate of state of mind theory draws difference between negligence and intention which involve mental attitude of the actor/doer towards the outcome of the act. This implies that a person is not guilty of negligence if he does not desire the consequences but nonetheless owing to

88. Fitzgerald P J, *Salmond on Jurisprudence*, London, Sweet and Maxwell , 12th Ed., 1963, p390
89. D.D. Basu, *Law of Torts*, 8th Ed., Practice Hall of India Limited, 1977, p. 22.
90. *Lievre Vs Gould (1893)1 QB 491.*
91. *Grant Vs Australian Knitting Mills (1936) AC 86*

carelessness or indifference, it may occur. Thus, a careless man is he who does not care-who is not anxious that his activities may cause loss to others. On the other hand, willful or intentional wrong doer is one who desires to bring out the anticipated consequence.

Therefore, negligence and wrongful intention are mutually inconsistent and mutually exclusive state of mind. The *Salmond* perspective was criticised by, *Holmes, Roscoe Pound and Edginton*[92] who considered mental theory as erroneous. To them, negligence does not involve or presuppose inadvertence or any other mental characteristic, quality, state or process. In fact, to Edginton, negligence is unreasonably a dangerous conduct. However, it should be stated that it is not within the scope of this thesis to venture into jurisprudential details of the concept of negligence. The above views are relevant in order to understand the perception of authors as to when an act amounts to negligence. Therefore, the essence of this part is to provide a working definition within the objectives of this thesis.

On this note, the researcher is not relying on the theories designed by scholars because none of the theories has been able to depict the contents of negligence. The theories are basically theoretical and would not be useful within the objectives of this thesis. Thus, the researcher intends to adopt the definition of negligence as given by Lord Wright in the case of *Lochgelly Iron and Coal Company v Mullan*[93] where he defined, negligence. He said, in law, to constitute negligence, it must possess the following three conditions;

a) That the defendant owes to the plaintiff a legal duty to exercise care;
b) That the defendant was in breach of that duty that is failure to exercise that duty of care
c) That as a result of breach, the plaintiff suffered damage.

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92. P. Edginton*, Law of Torts*, 1961, Oxford University Press, p 852.
93. 1934, AC 1

Thus, in strict legal analysis, negligence means more than needless or careless conduct, whether in omission or commission. It connotes the complex concept of duty, breach and damage suffered by the person to whom the duty is owed. The above definition is adopted because it has highlighted the major components of negligence which overtime has been a guiding principle to the determination of question as whether a person is negligent or not both in Nigeria and beyond.

To succeed in an action for negligence under the law of torts, a plaintiff must prove that the Defendant owed to the plaintiff a duty of care, that the Defendant had violated that duty of care, and that the plaintiff suffered some injury as a result of the breach of duty of care. Accordingly, before going into the question as to whether a breach of the duty has occurred, it is necessary to first resolve the issue as to existence or otherwise of a duty of care and the degree of such duty as well as standard of care It is only after this that an examination into the actions of the defendant and as to whether a breach has occurred, would become necessary.

2.2.2 Medical Negligence

The medical profession is considered a noble profession because it helps in preserving life. A patient generally approaches a doctor or hospital based on his reputation. Expectations of a patient are two-fold: doctors and hospitals are expected to provide medical treatment with all the knowledge and skill at their command and secondly they will not do anything to harm the patient in any manner either because of their negligence, carelessness, or reckless attitude of their staff. Though a doctor may not be in a position to save his patient's life at all times, he is expected to use his special knowledge and skill in the most appropriate manner keeping in mind the interest of the patient who has entrusted his life to him. Therefore, it is expected

that a doctor carry out necessary investigation or seeks a report from the patient. Furthermore, unless it is an emergency, he obtains informed consent of the patient before proceeding with any major treatment, surgical operation, or even invasive investigation. Failure of a doctor and hospital to discharge this obligation is essentially a tortuous liability. A tort is a civil wrong (right *in rem*) as against a contractual obligation (right *in personam*) a breach that attracts judicial intervention by way of awarding damages. Thus, a patient's right to receive medical attention from doctors and hospitals is essentially a civil right. The relationship takes the shape of a contract to some extent because of informed consent, payment of fee, and performance of surgery/providing treatment, etcetera. while retaining essential elements of tort.

In the case of *Dr. Laxman Balkrishna Joshi v Dr. Trimbark Babu Godbole and Anr.*[94]*, and A.S.Mittal v. State of U.P.*[95], it was laid down that when a doctor is consulted by a patient, the doctor owes to his patient certain duties which are:

i. Duty of care in deciding whether to undertake the case,
ii. Duty of care in deciding what treatment to give, and
iii. Duty of care in the administration of that treatment.

A breach of any of the above duties may give a cause of action for negligence and the patient may on that basis recover damages from his doctor. In the aforementioned case, the apex court inter alia observed that negligence has many manifestations it may be active negligence, collateral negligence, comparative negligence, concurrent negligence, continued

[94]. AIR 1969 SC 128
[95]. AIR 1989 SC 1570

negligence, criminal negligence, gross negligence, hazardous negligence, active and passive negligence, willful or reckless negligence, or negligence per se.

Black's Law Dictionary defines negligence per se as:

> "Conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is in violation of statute or valid Municipal ordinance or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law for the protection of person or property, so constitutes."

There exists a duty to obtain prior consent (with respect to living patients) for the purpose of diagnosis, treatment, organ transplant, research purposes, disclosure of medical records, and teaching and medico-legal purposes. With respect to the dead in regard to pathological post mortem, medico-legal post mortem, organ transplant (for legal heirs), and for disclosure of medical record, it is important that informed consent of the patient is obtained. Consent can be given in the following ways:

a. Express Consent: It may be oral or in writing. Though both these categories of consents are of equal value, written consent can be considered as superior because of its evidential value.

b. Implied Consent: Implied consent may be implied by patient's conduct.

c. Tacit Consent: Tacit consent means implied consent understood without being stated.

d. Surrogate consent: This consent is given by family members. Generally, courts have held that consent of family members with the written approval of 2 physicians sufficiently protects a patient's interest.[96]

[96] . R.F. Salmond, *The Law of Torts*, 17th Ed., Sweet and Maxwell, 1977 p 193.

e. Advance consent, proxy consent, and presumed consent are also used. While the term advance consent is the consent given by patient in advance, proxy consent indicates consent given by an authorized person. As mentioned earlier, informed consent obtained after explaining all possible risks and side effects is superior to all other forms of consent.

The Encyclopedia Britannia[97] defines Medical negligence as "Bread of duty by a doctor to his patient to exercise reasonable care or skill resulting in some bodily, mental or financial disability". Further, the regulatory instrument for medical practitioners also known as the Code of Medical Ethics[98] highlights among others what constitutes Professional Negligence. Some of these are:

i. Failure to attend promptly to a patient requiring urgent attention when the practitioner was in a position to do so.
ii. Manifestation of incompetence in the assessment of a patient.
iii. Making an incorrect diagnosis particularly when the clinical features were so glaring that no reasonable skillful practitioner could have failed to notice them.
iv. Failure to advise, or proffering wrong advice to, a patient on the risk involved in a particular operation or course of treatment, especially if such an operation or course of treatment is likely to result in serious side effects like deformity or loss of an organ.
v. Failure to obtain the consent of the patient (informed or otherwise) before proceeding with any surgical procedure or course of treatment, when such consent was necessary.
vi. Failure to remove foreign objects inserted into a patient
vii. Failure to take a full medical history

[97]. Vol. 23 775
[98]. *Section 28 of the Rules of Professional Conduct for Medical and Dental Practitioners*

2.2.3 Surgical Negligence

The expression surgical negligence does not exist in a vacuum as some sort of clearly defined legal concept. It is always related to a particular fact or situation. It is for this reason that judicial decision in this area seldom creates any precedent that will necessarily dictate conclusion in a subsequent case[99].

There is no clear elucidation in law as to the nature of medical negligence. This vagueness leads to a state that it is not only a tort but also a crime. Yet, the law of surgical negligence is generated out of civil action. For instance, gross negligence or involuntary manslaughter constitutes criminal negligence. However, a simple carelessness or a mere failure of the practitioner to take care amounts to tort. Gross criminal negligence occurs where the practitioner or health care provider has disregards for the life or safety of the patient and such act attracts punishment as a crime[100].

In terms of tort, negligence is said to be the breach of a duty caused by omission to do something which a reasonable man would or doing something a prudent and reasonable man would not do[101]. This makes no difference between medical negligence and any other type of negligence. Medical and non-medical negligence are the same.

On this note, according to Gupta Kiran[102], surgical negligence is defined as the failure of a medical practitioner to provide proper care and attention and exercise those skills which a

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99. C. J. Lewis, *Clinical Negligence: A Practical Guide*, Butter Worths Press, London, 5th edition, (2001) p 139
100. *R v Adomako (1995)1 AC 624*
101. *Paramananda KataraVs Union of India 1989 ACJ 1000 (SC)*
102. G. Kiran "The Standard of Care and Proof in Medical Profession: A Shift from Bolam to Bolitho" (2011-2012) 1 National Capital Law Journal, XIV-XV.

prudent, qualified person would do under similar circumstances. It is a commission of an act by a surgical professional which deviates from the accepted standards of practice of the medical community, leading to an injury to the patient. It could be defined as an incompetent unreasonable care and lack of skill of the surgeon to his patient. The incompetence could lead to adverse effect to his patient, whether it is history taking or some clinical examination, investigation, even if it is diagnosis or treatment that has resulted in injury, death, or an unfavorable outcome. Failure to act in accordance with the medical standards in vogue and failure to exercise due care and diligence are generally deemed to constitute medical negligence.

Medical negligence is also defined as the failure of the healthcare provider to exercise the ordinary care and skill a reasonably prudent and qualified person would exercise under the same or similar circumstance. He went further to explain who the healthcare providers are; the doctors, nurses, surgeons, anesthetists, radiographers, dentists etcetera.[103]

Surgical negligence in a legal sense is a subdivision of professional negligence which is a division of the general concept of negligence that relates to the circumstances in which the surgeon/medical practitioner who represented himself or herself as having special knowledge breaches his or her duty to take care of his or her patient[104]. The general principle applies in showing that the surgeon who owed the duty of care is in breach of that duty. This means that once a surgeon has agreed to treat the patient, the legal relationship between surgeon and patient is established. This suggests that a medical relationship is formed and this relationship

[103] . Resolution Law Firm, Liability and Proof of Medical Negligence in Nigera, < https://www.mondaq.com/nigeria/professional-negligence/1004164/liability-and-proof-of-medical-negligence-in-nigeria> accessed on 29/04/2022

[104]. Jackson & Powell, *Medical Negligence Litigation: Time for Reform*, PS Ranjan, Medical Law and Ethics.

resulted in duty to take care. The basis of this legal relationship is the rule of reasonable reliance by the claimant on the skills of the defendant. On this note, the court observed that[105] Where a person is so placed that others could reasonably rely upon his judgment or his skill or upon his ability to make careful inquiry, and a person takes it upon himself to give information or advice to, or allows his information or advice to be passed on to, another person who, as he knows or should know, will place reliance upon it, then a duty of care will arise.

According to common law system of negligence, the medical practitioner has discretion in choosing the treatment which he proposes to give to the patient. This discretion is wider in cases of emergency. But, he must bring to his task, a reasonable degree of skill and knowledge and must exercise a reasonable degree of care according to the circumstances of each case. Therefore, a surgeon who holds himself out ready to give surgical advice and treatment has by implication held out that he is possessed of skill and knowledge for such purpose. As a result, when he is consulted by a patient, he owes certain duties, namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give, and a duty of care in the administration of the treatment. The standard for existence of duty of care in giving advice was explained by the court in more restricted terms as[106].

What can be deduced from the Hedley Byrne case, therefore, is that the necessary relationship between the maker of a statement or giver of advice (the adviser) and the recipient who acts in reliance on it (the advisee) may typically be held to exist where;

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[105]. *Hedley Byrne v. Heller, (1964) AC 465*

[106] . *Caparo Industries Plc v Dickman(1990) 2 AC 605*

1. The advice is required for a purpose, whether particularly specified or generally described, which is made known, either actually or inferentially, to the adviser at the time when the advice is given.
2. The adviser knows, either actually or inferentially, that his advice will be communicated to the advisee, either specifically or as a member of an ascertainable class, in order that it should be used by the advisee for that purpose.
3. It is known, either actually or inferentially, that the advice so informed may likely to be acted upon by the advisee for that purpose without independent inquiry and
4. It is so acted on by the advisee to his detriment.

So, a medical practitioner owes a duty of care to patients to ensure that they do not suffer any unreasonable harm or loss. However, where such a duty is found to be violated, a legal liability is imposed upon him or her, the owner of the duty, to compensate the victim for any losses they incur.

Surgical negligence can occur at various stages. For instance, a health care provider may misdiagnose a problem, fails to treat the injury or illness properly, administer the wrong medication, and fails to adequately inform a patient about the risks of a procedure or about alternative treatments. In fact, surgical negligence comprises the majority of professional negligence lawsuits. This is not to say that medical professionals are more prone to committing negligence, but that they are the target of more professional negligence lawsuits. The legal position of surgical negligence in India has been described in several leading judgments. In the leading case of *Bolam vs. Friern* Hospital Management Committee[107], where Mc Nair J. stated that where you get a situation which involves the use of some special

[107]. *Bolam vs. Friern Hospital Management Committee, [1957] 1 WLR.*

skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. Counsel for the plaintiff put it in this way, that as it concerns the medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms to one of those proper standards of curse he should not be seen as been negligent. If a surgeon is not acting on the basis of competent practice hoping that because a body of opinion has a contrary view he should not be liable, he is joking with his job. But that does not mean to say that any medical practitioner can obstinately and pig-headedly move on with some outdated technique he cannot equally get away with it.

To sum up, medical negligence maybe described as want of reasonable care and skill or willful negligence on the part of a doctor in respect to acceptance of a patient, history taking, examination, diagnosis, investigation, treatment (medical or surgical) etcetera., resulting in injury or damage to the patient. For instance, prescribing treatment without taking history, without recording the signs and symptoms of disease, without investigation and diagnosis or not to carry out necessary tests before starting administration, failure to issue warning regarding side effects of the drugs or not monitoring the treatment, leaving foreign articles in the operation site, or performing operation on the wrong side of the patient, wrong dosage of

injection, use of wrong drug or wrong gas during the course of anaesthesia are all examples of medical negligence. Therefore, medical negligence occurs when a doctor, dentist, nurse, surgeon or any other medical professional performs his job in a way that deviates from the accepted medical standard of care. In keeping with car accident analogy, if a doctor breaks the rules regarding how to treat a patient, and does something that is against the rules, then that doctor has failed to perform his duty, and is said to be negligent. However, the court will be having wide discretionary power in deciding the issue of surgical negligence.

2.2.4 Tort

The province of tort is to allocate responsibility for injurious conduct so states Lord Denning. A tort has been defined as 'a civil wrong for which the remedy is a common-law action for unliquidated damages, and which is not exclusively the breach of a contract or the breach of a trust or other merely equitable obligations.[108]

According to Winfield, tortuous liability arises from the breach of a duty primarily fixed by law; such duty is towards persons generally, and its breach is redressible by an action for unliquidated damages.

The main difference is these two definitions are: while *Salmond* believes that 'there is a general principle of liability in tort and that all actions are actionable in the absence of a just cause or excuse. Winfield argues that: there are a number of specific torts, and that unless the damage of injury suffered can be brought within the scope of one or more of these torts there is no remedy.[109]

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[108]. Salmond, *Law of Torts*, London, Sweet & Maxwell, 1957, p.37

[109]. C F Padfield, *Law Made Simple*, London, W.H. Allen, 1979, pp.195-196

As a general rule, where a person suffers from unlawful harm or damage at the hands of another, an action in tort will lie. An action will lie when Mr A negligently collides with Mr B's stationary car on a road and causes damage to it. However, there are instances where harm is done by one person to another and the law is silent on a remedy; this is known as *damnum sine injuria* (damage without legal wrong).[110] The law of tort is concerned with those situations where the conduct of a party causes harm or threatens harm to the interests of another party or other parties.[111]

The boundaries of tort law are defined by common law and state statutory law. Judges, in interpreting the language of statutes, have wide latitude in determining which actions qualify as legally cognizable wrongs, which defenses may override any given claim, and the appropriate measure of damages.

Torts fall into three general categories: intentional torts (*e.g.*, intentionally hitting a person); negligent torts (*e.g.*, causing an accident by failing to obey traffic rules); and strict liability torts (*e.g.*, liability for making and selling defective products). Intentional torts are wrongs that the defendant knew or should have known would result through his or her actions or omissions. Negligent torts occur when the defendant's actions were unreasonably unsafe. Unlike intentional and negligent torts, strict liability torts do not depend on the degree of care that the defendant used. Rather, in strict liability cases, courts focus on whether a particular result or harm manifested.

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110. *Ibid.*
111. H Street, *The Law of Torts*, London, Butterworths Pub. 7th Edn., 1983, p.3

There are numerous specific torts including trespass, assault, battery, negligence, products liability, and intentional infliction of emotional distress. There are also separate areas of tort law including nuisance, defamation, invasion of privacy, and a category of economic torts.

The law recognizes torts as civil wrongs and allows injured parties to recover for their losses. Injured parties may bring suit to recover damages in the form of monetary compensation or for an injunction, which compels a party to cease an activity. In certain cases, courts will award punitive damages in addition to compensatory damages to deter further misconduct.[112]

In the vast majority of tort cases, the court will award compensatory damages to an injured party that has successfully proven his or her case. Compensatory damages are typically equal to the monetary value of the injured party's loss of earnings, loss of future earning capacity, pain and suffering, and reasonable medical expenses. Thus, courts may award damages for incurred as well as expected losses.

When the court has an interest in deterring future misconduct, the court may award punitive damages in addition to compensatory damages. For example, in a case against a manufacturer for a defectively manufactured product, a court may award punitive damages to compel the manufacturer to ensure more careful production going forward.

In some cases, injured parties may bring suit to obtain an injunction rather than monetary relief. The party seeking an injunction typically must prove that it would suffer considerable or irreparable harm without the court's intervention.

[112] . *Ibid*

Torts are distinguishable from crimes, which are wrongs against the state or society at large. The main purpose of criminal liability is to enforce public justice. In contrast, tort law addresses private wrongs and has a central purpose of compensating the victim rather than punishing the wrongdoer. Some acts may provide a basis for both tort and criminal liability. For example, gross negligence that endangers the lives of others may simultaneously be a tort and a crime.

Some actions are punishable under both criminal law and tort law, such as battery. In that case, ideally tort law would provide a monetary remedy to the plaintiff, while criminal law would provide rehabilitation for the defendant, while also providing a benefit to society by reforming the defendant who committed assault.

Tort law is also distinct from contract law. Although a party may have a strong breach of contract case under contract law, a breach of contract is not typically considered a tortious act.

2.2.5 Tortuous Liability

Tortuous liability can arise in case of negligence of a surgeon treating a patient. This liability is meant to serve two main purposes. Firstly, it provides compensation to those injured as a result of negligence, thereby acting as a source of insurance. Secondly, it serves as a deterrence that will prevent future occurrence of the negligence.[113]

The tortuous liability is usually a civil action brought by the patient or his heirs. Tortuous liability can either be primary or vicarious. A vicarious liability should not be confused with

[113] . P. Kimuyu, *Principles of Tortuous Liability,* https://www.grin.com/document/381305#:~:text=Tortuous%20liability%20is%20applied%20in,of%20the%20law%20of%20obligation. *Accessed on 27/05/2022*

primary liability of hospitals. Apart from vicarious liability, a hospital may commit a breach of duty of care, which it owes to another, i.e. a hospital may be in breach of its own duty to another. An example of this is where a hospital is at fault for selecting an unskilled person as its staff who conducts himself in a wrongful manner, or allowing such a person to continue in employment; or where it provides defective equipment for use by the health care team under its employment[114].

When we refer to vicarious liability, it is a liability where a master incurs damages to the third party because of a wrong committed by his servant in his employment. This does not matter whether the master didn't commit the offence himself. But for a liability of a master to occur, there must be a relationship of master/servant which is distinct from employer and independent contractor. The management of the hospital is always vicariously liable for the offence its staff commits. This is because the healthcare team is the servant of the hospital who employed them. Examples of these are Surgeons, Radiographers, Pharmacists, Nurses, full time Assistant Medical Officers, and Anesthetists and so on. These are servants of the hospital authority being referred to as being vicariously liable.

Vicarious liability of the master arises on the primary liability of the servant. The servant is the principal tort feasor while the master is the accessory. Thus, a plaintiff could sue both the health care provider and the hospital jointly. He may also sue either of them. The usual thing is to join the employer as a defendant. At times, the plaintiff may not be able to specifically identify which of the several servants of the master was negligent. For example, a patient who has been injured during an operation in a hospital may not be able to identify which one or more of the team of surgeons, anesthetists, nurses, and so on, are involved in the operation, was careless.

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[114]. I. P. Enemo, *The Law of Tort,* Enugu, Chenglo Ltd, 2007, p. 306.

It was held in Cassidy vs. Ministry of Health[115] that, in such a situation, the hospital authority will be vicariously liable, unless it can show that there was no negligent treatment by any of its servants. It is usually better for an injured plaintiff to join the hospital (master) as a defendant because; it is richer than any of its servants and will be in a better position to pay than the servant (provider).

2.2.6 Medical Ethics

Medical ethics is a type of professional ethics. In modern medicine, ethics is believed to have started in the 18th century; a physician by name Thomas Percival authored a book on medical ethics which is believed to be the beginning and development of medical ethics code of conduct[116]. It is Dr. Thomas Percival who coined the term medical ethics after publishing his book in 1803. Medical ethics is the conduct required from any medical practitioner, it is necessary for the physician as it acts as a guide in making clinical decisions[117].

Medical ethics is the ethical, morals and values aspect that guides the medical profession and its allies and it consists of interdisciplinary knowledge[118]. It guides decision making, medical practice, medical education and research in medicine[119]. There have been ethical guidelines which must be followed by healthcare workers in the history of the medical profession.

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115 . *[1951] 2 K.B. 343*

116 . R. Ciliberti, *Thomas Percival discussing the Foundation of Medical Ethics*. ACTA Biomedical . 2018, 89(3), 343-348

117. Gomez-Gomez C, Gonzalez-Melendez R, *et al*, H. Journal of Human Health Research Ethical Delimma and Research. 2018, Vol 3: 101

118. Jegede A, Ajayi I, Akintola S, Falade C, Dipedu IO et al. *Ethical Issues in the COVID-19 Pandemic Control Preparaedness in a Developing Country*,. Pan African Medical Journal. 2020, 35(2),95. doi.10.11604/pamj. SUPPL.2020.35.23121

119. Elsayed DE, Ahmed REM. *Medical Ethics : What is it? Why is it important*? Sudanese Journal of Public Health. 2009, 4(2), 283-286

In 1949, the international code of medical ethics has been adopted by the World Medical Association in London [120]. Every national medical board has a code of conduct to guides the practice of medicine in that country. For instance, in Nigeria, medical ethics is governed by the Medical and Dental Council of Nigeria (MDCN) which published a booklet titled 'A Code of Conduct' which is handed over to every new medical and dental graduate at the time of induction into the medical and dental profession. Medical ethics is a type of applied ethics. The basis of the medical ethics is centered on the Hippocratic Oath which is an oath is taken by every dental and medical graduate at the time of been inducted into the medical and dental profession. They are set of rules, regulations and guidelines that guides and governs physicians in carrying out their duties[121].

Medical ethics focuses on the relationship that exists between the doctor and their patient, which includes the legal and ethical implications. Hospitals also ensure that their employees practice medical ethics to prevent litigations which can cause loss of resources to the health facilities. Medical ethics guides decision making of medical practitioners as patient centered care is based on medical ethics. It is expected that medical practitioners are well equipped with medical skills and knowledge and also they are familiar with the medical ethics and its legal implications. Medical ethics promotes the respect of patient and confidentiality. Medical ethics is important in the practice of medicine therefore it is taught in most medical and dental schools both at the undergraduate and postgraduate levels. It is applied in all clinical settings as well as the medical workplace and in research; it encompasses other disciplines such as history, philosophy, theology, anthropology and sociology. The different

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120. *Ibid*

121. M. Munyaradzim, *Critical reflections on the Principle of Beneficence in Biomedicine*, Panafrican Medical Journal . 2012. <http://www.panafricanmed.journal.com/content/article/> accessed 1st July 2022

categories of professionals involved in providing healthcare practice medical ethics[122]. It is the duty of every physician to practice medical ethics in every consultation with the patient.

Medical ethics is important both in medical practice which involves the patient doctor relationship and in medical research. Some of the roles of medical ethics are:

1. It provides standards in the professional relationship between the physician and their clients or patient hence provides guidelines in the prevention of litigation[123]
2. The social capital in the professional relationship is established with members of the community.
3. Medical ethics is implemented in decision making by both the physician and the patient[124].
4. Medical ethics provides moral values necessary in providing solutions to ethical dilemma.
5. It provides privacy, confidentiality and truthfulness in the doctor-patient relationship.
6. Medical ethics promotes health, wellbeing, respect decision making, dignity, justice and accountability in the medical profession.
7. Medical ethics helps in promoting good and quality medical care by identifying, analyzing and attempting to resolve the ethical problems that arise in medical practice[125].
8. Medical ethics promotes diligence and proper training skills among healthcare professionals.

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122. Canadian Nurses Association, *Code Of Ethics For Registered Nurses*,< http:/ca/ethics. www.cna.aiic.ca> accessed 27/05/2022

123 SR Moosavi, Mousavi SM, Heydari A, *et al*, *Role of Medical Ethics In Health Economics*. International Journal of Medicine and Medical Sciences. 2010, 2(12), 387-390

124. Josipovic-Jelic Z, I. Soljan, *Clinical Ethics Delimmas in the Theory and Practice,* ACTA Clinical Croatia. 2007, 46, 325-330

125 . D.E. Pimentel, Oliveira CB, Vieira MJ, *Teaching of Medical Ethics: Students Perception in different period Of the Course*, Review of Medicine in Chile. 2011, 139: 36-44

9. Medical ethics helps in the prevention of unethical practices such as negligence and malpractice.

2.3: Summary of Review

This chapter has examined some prominent concepts relating to the present study. The concept of negligence, surgical negligence, tort and tortuous liability were examined in order to lay the foundation as to when a medical practitioner may be held liable in Tort for acts done or negligence for omissions committed . The chapter also examines the various schools of thoughts and their various contributions to the subject. However, opinions of different authors on professional medical negligence abound, the thin lines of disagreement notwithstanding. The court also has at some material points or the other held views that have helped in shaping the discourse of professional medical negligence in Nigeria. These views are succinctly summarized.

Nigeria has had an increasing number of cases recording medical negligence that results to the death and lasting deformity of persons. This has continued to be so because of low level of awareness on the legal implications of the negligent actions of the medical and health practitioners. Rather than keep quiet and watch these cases on the rise every day, it is imperative to raise the consciousness of the people which includes the medical and health practitioners as well as patients to enable both parties to be sufficiently armed with the requisite knowledge of the implications of their actions and the necessary steps to take in any event of violation.

According to Alderson B., in *Blyth v. Birmingham Water Works Company Co. (1856)*1

> "Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and

> reasonable man would do, or doing something which a prudent and reasonable man would not do."

Simply put therefore, "negligence is the breach of a legal duty to take care which results in damage, undesired by the defendant to the plaintiff.[126] Negligence in medical practice ordinarily implies that the medical practitioner had the consent of his patient to treat him, but such treatment did not conform with the standards imposed on the medical practitioner by law.

Medical Negligence is the omission to do what a reasonable medical practitioner guided by those considerations which ordinarily regulate medical practice would do, or doing something which a prudent and reasonable medical practitioner would refrain from doing under similar circumstances and as a result of which, some harm befalls he patient.[127]

Dada[128] however, argues that medical negligence is not different in law from any other type of negligence. He believes that it is used to be referred to as ‘’malpractice’’ though that is not strictly synonymous, as other forms of irregular medical practice may be malpractice, not sounding in negligence. Inn medico-legal parlance, medical negligence has been defined as ;

The failure of a health care provider to exercise the ordinary care and skill a reasonably person would exercise under the same or similar circumstances.

Osuagwu posits that medical negligence is the omission to do what a reasonable medical practitioner guided by those considerations which ordinarily regulate medical practice would

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126 . Winfield & Jolowicz on Torts, by W.V.H. Rogers, Sweet and Maxwell London, 1975 P.5. Osuagwu, E. M;Ethics and Medicolegal Aspects of Medical practice [Lagos, Jaro industries Ltd, 2010] see also *Blyths v. Birmingham Waterworks Co [1956] LR 11 Ex 781 at 784*

128 J.A, Dada ;Legal Aspects of Medical Practice in Nigeria [Calabar University of Calabar Press, 2003], p.87

do, or doing something which a prudent and reasonable medical practitioner would refrain from doing under similar circumstances and as a result of which, some harm befalls the patients.[129] This was also the position of the court in *Blyths v Birmingham Waterworks Co.*[130]

For *Dada*[131], Medical Negligence is not different in law from any other type of negligence. Dada argues that medical negligence is a term used to refer to 'malpractice', though this is not strictly synonymous, as other forms of irregular medical practice may be malpractice, not sounding in negligence.

For *Dieter*, the commonest and by far the most potent basis of tort liability in medical malpractice cases, however, is negligence.[132]

When a medical practitioner breaches his or her duty of care to patients or any other duties, the issue of medical negligence arises. The Nigerian Supreme Court in *U.T.B (Nig) v. Ozoemena*,[133] defined negligence as: Lack of proper care and attention; careless behavior or conduct; a state of mind which is opposed to intention; the breach of duty of care imposed by common law and statute resulting in damage to the complainant.

Medical negligence can also be defined as improper, unskilled, or negligent treatment of a patient by a physician, dentist, nurse, pharmacist, or any other healthcare professional. It is significant to note that other healthcare providers such as nurses, pharmacists, laboratory attendants and any other healthcare provider can be liable for medical negligence, contrary to

129 E. M. Osuagwu, *Ethics and Medicolegal Aspects of Medical Practice, Lagos, Jaron Industries Ltd., 2010, 54*

130 *Blyth v Birmingham Waterworks Co (1956) LR 11 Ex 781 at 784*

131 J.A., Dada, *Legal Aspects of Medical Practice in Nigeria, Calabar, University of Calabar Press, 2003 87*

132 G. Dieter, *International Medical Malpractice Law, J.C.B Mohr, London, 1988, 31*

133 *U.T.B (Nig) v. Ozoemena* ***(2007) 1 SC (Pt. 2) 21***

the general belief that only doctors can be liable for medical negligence.[134] The Supreme Court in Idaho held that 'the gist of of malpractice action is negligence'.[135]

For *Akhabue*, the concept of negligence connotes a conduct which falls below rhe standard established by law for the protection of others, against unreasonable risk of harm; it is a departure from the conduct expectable of a reasonable prudent person under like circumstances. Negligence is an area of the law of torts which essentially deals with compensation for civil wrong done due to the acts and omissions of others.[136]

Olayiwole views strongly that professional medical negligence is different from other areas of practice due to its overriding importance. Issues of liability for professional medical negligence are quite complex because by and large, medical practice is highly subjective.[137]

The Court *in Bolam Case* held that negligence means failure to act in accordance with the standards of reasonably proficient medical practitioner at the time, the injury was committed to the patient. In this case, McNair J stated pre-emptive principles on the subject now known as the 'Bolam's Test'.[138]

> *Where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man*

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134 M. Abdusalam, A Review Of Medical Negligence In The Nigerian Healthcare Sector: Utilising The Law As A Panacea, ASP Ajibade & CO, https://www.mondaq.com/nigeria/healthcare/1266406/a-review-of-medical-negligence-in-the-nigerian-healthcare-sector-utilising-the-law-as-a-panacea-, accessed21/05/2023

135 *Billings v Sisters of Mercy of Idaho (1964) 389 P2d 224, 230*

136 D. A. Akhabue, 'Negligence in Nigeria-Not at Claimant's Beck and Call', {2014} (1)(6), *International Journal of Law and Legal Jurisprudence Studies 2.*

137 A. Olayiwole, Medical Health Practice in Nigeria, McDon Publishers, Ibadan, 2003, 34

138 *Bolam v Friern Hospital Management Committee (1957) 2 All ER*

> *exercising that particular art. In case of medical men, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. There may be one or more perfectly proper standards and if he confirms with one of these proper standards, then he is not negligent.*

In the celebrated case of *Sidaway v Bethlem RHG*, the House of Lord agreed that medical practitioners must guide their patients as recognized by other medical ractitioners as being suitable. Hence, Lord Bridge stated that:

> *Broadly, a doctor's professional functions may be divided into three phases; diagnosis, advice and treatment. In performing his functions of diagnosis and treatment, the standard by which English law measures the Doctor's duty of care to his patient is not open to doubt.*[139]

In *Maynard v Midlands RHA*, the House of Lords held that in ascertaining negligence, it would not choose between different bodies of proficient medical opinion but one acceptable body would suffice even though another competent body holds a different opinion. However, the ordinary skill of an ordinary competent man may be difficult to ascertain and may lead to problems. The House of Lords boldly pointed out that:

> *It is not enough to show that subsequent events show that there is a body of competent professional opinion which considers there was a wrong decision, if there also exists a body of professional opinion equally competent, which supports the decision as reasonable circumstances…A doctor who professes to exercise a special skill must exercise the ordinary skill of his specialty. Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to another: but that is no basis for a conclusion of negligence.*

In *Whitehouse v Jordan*, the House of Lords had to determine whether the acts of an obstetrician in attempting to deliver a baby by forceps, pulled to long and applied

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[139] *(1985) 1 All ER 643*

too much force on the claimants head. It was further alleged that the doctor continued traction with the forceps after obstruction of the ischial spines. Lord Edmund Davies decided that:

> To say that a surgeon committed an error of judgment is wholly ambiguous, for while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising clinical judgment may be so glaringly below proper standards as to make a finding of negligence inevitable…' the test is the standard of the ordinary skilled man in exercising and professing to have that special skill'. If a surgeon fails to measure up to that standard in any respect (clinical judgment or otherwise), he has been negligent and should be so adjudged.[140]

However, *Adejumo*[141] draws a distinction between medical error and medical negligence. A medical error medical error is said to occur when a medical practitioner chooses an inappropriate or unorthodox method of care or when a medical practitioner uses an appropriate method of care in an improper manner.[142] A medical error is classified as an omission or commission with potentially negative consequences.[143]

Flowing from the above definition, there exist a meticulously thin line between medical error and medical negligence, which is an existence of 'injury'. Therefore, a claim of medical negligence that is hinged solely on medical error will most likely fail in court. However, while an aggrieved claimant cannot claim damages under medical negligence, such a person has alternative options of redress such as violation of human rights, lack of informed consent, amongst others.

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140 *Whitehouse v Jordan (1981) 1WLR 246*

141 . O. A. Adejumo, "Legal Perspectives On Liability For Medical Negligence and Malpractices in Nigeria," Pan African Medical Journal, 35. Available at: https://doi.org/10.11604/pamj.2020.35.44.16651.

142 *Ibid*

143 *Ibid*

2.4 Gap in Knowledge

From the foregoing review of the position of different authors and contributors to developing the medical law jurisprudence, it is gleaned that a common denominator exists amongst all of them which is that of acceptable standard of practice that should e maintained by all medical practitioners.

However, there is an obvious gap which this thesis seeks to fill. Firstly, is the one of codification of all acceptable and conventional medical practices. Often, medical professionals are found relying on some practices that are termed conventional and they hide under this to escape from liabilities arising from their negligence or medical errors. It is important that all acceptable standards be reduced into a statute book and not just relying on mere conventions. This is to bring it within the realm of the positive law theory which advocates for it to be written down with elements of command, force and sanctions. Where this is done, the statute book can easily be referred to in the event of any medical negligence or malpractice and the recommended sanctions thereto invoked.

Again, a sufficient awareness on the rights of the patients is a gap that this thesis seeks to fill. There is a lacuna in the area of knowledge for patients, especially those from the Northern region. People in the rural areas have a way of attributing everything that happens to some supernatural and mystic powers. They hardly do know their rights, the expected minimum professional requirement for every medical practitioner, and the minimum or required standards for every medical practitioner. A patient who was erroneously injected with a wrongly prescribed fluid and begins to react to it convulsively sees it as the work of the

goddess of the river and does not probe into the possible medical cause. This thesis therefore seeks to fill this gap in knowledge.

2.5 Historical Evolution

The history of medical malpractice extends back several centuries. In fact, the first identifiable case of medical practice can be traced back to the year 1374.[144] It was caused by a surgeon that had attempted to repair his patient's mangled hand. However, after the treatment, the patient's hand still remained deformed. Unfortunately, that case was dismissed because of a procedural error.

Medical practice dates back to as far back as the 1511, 4th Century B.C. under the title of Hippocratic corpus. This first Medical Act of 1511 provided that none should practice physics or surgery (except graduates of Oxford or Cambridge) unless licensed by the Bishop of his Diocese. Before a license was granted the candidate was to be examined and approved by an expert panel summoned for the purpose by the Bishop. A continuing penalty of £5 per month was laid down for unlicensed practice. An amending Act was passed in 1542 exempting from the penalties for unlicensed practice divers honest persons with the knowledge of the nature, kind and operation of certain herbs, roots and water and the using and ministering of them to such as be pained with customable disease[145]. The exemption could be claimed only by those who practiced without fee. (College of Physicians vs. Butler, 6 Charles 1)[146].

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144 . Friedman and Friedman, *History of Medical Practice,* < https://www.friedmantriallawyers.com/practices/medical-malpractice/the-history-of-medical-malpractice/#:~:text=The%20history%20of%20medical%20malpractice%20extends%20back%20several%20centuries.,patient's%20hand%20still%20remained%20deformed.> accessed 01/06/2022

145. An amending Act 1542 exemption from the penalties for unlicensed practice

146. *College of Physicians v Butler, 6 Charles (1st Medical Practice in the hand of Ecclesiastical Authorities)*

The first of medical practice was under the control of the Catholic Church, since at that time the Catholic Church was the only – Corporate Body with the necessary organizational skills to administer the Act. The establishment and growth of the several medical societies provided alternative means of licensing persons to practice medicine. The College of Physicians was founded by Royal Charter in 1518[147].

Its functions, exercised in and for seven miles around London, were to grant licenses to those qualified to practice, to punish pretenders to medicine and also those who committed malpractice, whether by license or unlicensed persons. An act of 1540 established the United Company of Barber- Surgeons, bringing together the companies of Barbers, who performed minor surgery, and of surgeons into a single company. An act for the dissolution of the United Company, promoted by the surgeons, was passed in 1745 and in 1800 the College of Surgeons was formed. The eventual disappearance of the ecclesiastical authorities from the sphere of medical control, the conflicts and jealousies of the various licensing bodies and their efforts to safeguard ancient privileges and secure for their members rights of practice, are now of historical interest only.

Ever since then, the medical practice has witnessed systematic and geometrical growth and it has for a long time been regulated by the statutes of the profession. And to ensure professional competence, formal training in approved institutions is now a *sine qua non* for persons seeking to be admitted into the medical profession. It must be noted here that before the advent of a science oriented and regulated practice, the area of medicine was covered by traditional medicine men[148] who are known to be practitioners of the art of traditional medicine. They were also taken to be mystic in a primitive culture dealing with multifarious

147. College of Physicians was founded by Royal Charter in 1518

148. A. Ekong Bassey, *The legal Aspects of Medical Practice,* Calabar, Onward Publications, 1997, p. 1

and multidimensional ailments and medical conditions. They were known as (Father of all diseases). This can be explained why medical practice is not exclusive to only trained hands (conventionally trained). This is because in Nigeria today traditional medicine is on the increase called trado-medicalism and is thriving even more that the orthodox medical practice. There are in different shades and descriptions, the medical quacks, the homeopaths who parade themselves all over the country under all sorts of dubious titles.

Western medicine was not formally introduced into Nigeria until the 1860s, when the Sacred Heart Hospital was established by Roman Catholic missionaries in Abeokuta. Throughout the ensuing colonial period, the religious missions played a major role in the supply of modern health care facilities in Nigeria. The Roman Catholic missions predominanted, accounting for about 40 percent of the total number of mission-based hospital beds by 1960.

Mission-based facilities were concentrated in certain areas, depending on the religious and other activities of the missions. Roman Catholic hospitals in particular were concentrated in the southeastern and midwestern areas. By 1954 almost all the hospitals in the midwestern part of the country were operated by Roman Catholic missions. The next largest sponsors of mission hospitals were, respectively, the Sudan United Mission, which concentrated on middle belt areas, and the Sudan Interior Mission, which worked in the Islamic north. Together they operated hospitals or other facilities in the northern half of the country. Many of the mission hospitals remained important components of the health care network in the north in 1990.

The missions also played an important role in medical training and education, providing training for nurses and paramedical personnel and sponsoring basic education as well as advanced medical training, often in Europe, for many of the first generation of Western-educated Nigerian

doctors. In addition, the general education provided by the missions for many Nigerians helped to lay the groundwork for a wider distribution and acceptance of modern medical care. The British colonial government began providing formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading centers in the 1870s. Unlike the missionary facilities, these were, at least initially, solely for the use of Europeans. Services were later extended to African employees of European concerns. Government hospitals and clinics expanded to other areas of the country as European activity increased there. The hospital in Jos, for example, was founded in 1912 after the initiation there of tin mining.

Ownership of health establishments was divided among federal, state, and local governments, and there were privately owned facilities. Whereas the great majority of health establishments were government owned, there was a growing number of private institutions through the 1980s.

Hospitals were divided into general wards, which provided both outpatient and inpatient care for a small fee, and amenity wards, which charged higher fees but provided better conditions. The general wards were usually very crowded, and there were long waits for registration as well as for treatment. Patients frequently did not see a doctor, but only a nurse or other practitioner. Many types of drugs were not available at the hospital pharmacy; those that were available were usually dispensed without containers, meaning the patients had to provide their own. The inpatient wards were extremely crowded; beds were in corridors and even consisted of mattresses on floors. Food was free for very poor patients who had no one to provide for them. Most, however, had relatives or friends present, who prepared or brought food and often stayed in the hospital with the patient. By contrast, in the amenity wards available to wealthier or elite patients, food and better care were provided, and drug

availability was greater. The highest level of the Nigerian elite frequently traveled abroad for medical care, particularly when a serious medical problem existed.

CHAPTER THREE.
LEGAL AND INSTITUTIONAL FRAMEWORK.

3.1 Constitution of the Federal Republic of Nigeria 1999 (as amended).

The Constitution of the Federal Republic of Nigeria (referred to hereinafter as the Constitution) is the supreme law[149]. In fact, it is the *grund norm* through which all other laws derive their validity[150]. The implication of this is that any law which is inconsistent with the constitutional provisions shall be null and void to the extent of its inconsistency[151]. It is true that there are no explicit provisions in the constitution on legal framework on Medical practice. However, some provisions of the Constitution provide basic rights by implication, which can be expounded to protect Medical Practice. For instance, the constitution in chapter 4 has made ample provisions for some basic or fundamental rights. Some of these rights have direct link with the protection of a patient. Examples of these are: right to protection of human dignity, right to liberty and right to self- determination.

Also, from *Section 13 to Section 24* of the 1999 Constitution dealing with Fundamental Objectives and Directive Principles of State Policy, *Section 17* states thus:

(1) The State social order is founded on ideals of Freedom, Equality and Justice.

(2) In furtherance of the social order-

(a) Every citizen shall have equality of rights, obligations and opportunities before the law;

(b) The sanctity of the human person shall be recognized and human dignity shall be maintained and enhanced;

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149. *Section 1(1) of the Constitution of the Federal Republic of Nigeria, (CFRN) 1999 (as amended.)*
150. E. Malemi, *Constitutional Law in Nigeria,* Princeton Publishing Company, Ikeja, 2012, p.13
151. *Ibid*

(c) Governmental actions shall be humane;

(d) Exploitation of human or natural resources in any form whatsoever for reasons, other than the good of the community, shall be prevented; and

(e) The independence, impartiality and integrity of courts of law, and easy accessibility thereto shall be secured and maintained.

(3) The State shall direct its policy towards ensuring that-

(a) All citizens, without discrimination on any group whatsoever, have the opportunity for securing adequate means of livelihood as well as adequate opportunity to secure suitable employment;

(b) Conditions of work are just and humane, and that there are adequate facilities for leisure and for social, religious and cultural life;

(c) The health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;

(d) There are adequate medical and health facilities for all persons:

(e) There is equal pay for equal work without discrimination on account of sex, or on any other ground whatsoever;

(f) Children, young persons and the age are protected against any exploitation whatsoever, and against moral and material neglect;

(g) Provision is made for public assistance in deserving cases or other conditions of need; and

(h) The evolution and promotion of family life is encouraged.

Section 17 (3) of the above obligate the Nigerian government to direct its policies by ensuring that adequate healthcare facilities reach are made available to all citizens. It is the

responsibility of the government to ensure the mental and physical good health of itscitizenry and protection of its human dignity[152] . Although the above *Section 17* of the Constitution appears not to be justiciable by provisions of of the Constitution[153] which provides for judicial powers of the courts in Nigeria. The Section provides as follows:

(6) The judicial powers vested in accordance with the foregoing provisions of this section[154] -

(a) shall extend, notwithstanding anything to the contrary in this constitution, to all inherent powers and sanctions of a court of law

(b) shall extend, to all matters between persons, or between government or authority and to any persons in Nigeria, and to all actions and proceedings relating thereto, for the determination of any question as to the civil rights and obligations of that person;

(c) shall not except as otherwise provided by this Constitution, extend to any issue or question as to whether any act or omission by any authority or person or as to whether any law or any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution;

(d) shall not, as from the date when this section comes into force, extend to any action or proceedings relating to any existing law made on or after 15th January, 1966 for determining any issue or question as to the competence of any authority or person to make any such law.

It is submitted that regardless of the provisions of the Constitution in *Section 6(6)(c),* the right to adequate medical and health facilities for all persons is one and the same as the right to life and it is one primary right available to all persons irrespective of gender, economic

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152 . *Section 17(2)(b) CFRN 1999*

153 . *Section 6(6)(c) of the Constitution*

154 *Section 6(6)(c) CFRN 1999*

status or age. It is a right enshrined in various local[155] and international[156] legal instruments. The sacredness and sanctity of life is one that must be accorded its respect as every human deserves to live. By the natural existence of man in creation, every person should be regarded with equal value and treatment as no one is higher than the other. This is strengthened by the proclamation of the United Nations Declaration on Human and People's Right which provides that 'all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.'[157] No person is to be deprived of this right except in such circumstances prescribed by the law.[158]

Also, the right to personal liberty is provided for under *Section 35* of the 1999 Constitution of the Federal Republic of Nigeria which states;

(1) Every person shall be entitled to his personal liberty and no person shall be deprived of such liberty save in the following cases and in accordance with a procedure permitted by law –

(a) in execution of the sentence or order of a court in respect of a criminal offence of which he has been found guilty;

(b) by reason of his failure to comply with the order of a court or in order to secure the fulfilment of any obligation imposed upon him by law;

(c) for the purpose of bringing him before a court in execution of the order of a court or upon reasonable suspicion of his having committed a criminal offence, or to such extent as may be

155 *Section 33(1) of the 1999 Constitution of the Federal Republic of Nigeria* (as amended 2018).
156 *Article 3 of the United Nations Declaration on Human and People's Right 1948.*
157 *Article 1 (Ibid).*
158 *Section 33(2)(a-c) of the 1999 Constitution of the Federal Republic of Nigeria (as amended).*

reasonably necessary to prevent his committing a criminal offence;

(d) in the case of a person who has not attained the age of eighteen years for the purpose of his education or welfare;

(e) in the case of persons suffering from infectious or contagious disease, persons of unsound mind, persons addicted to drugs or alcohol or vagrants, for the purpose of their care or treatment or the protection of the community; or

(f) for the purpose of preventing the unlawful entry of any person into Nigeria or of effecting the expulsion, extradition or other lawful removal from Nigeria of any person or the taking of proceedings relating thereto: Provided that a person who is charged with an offence and who has been detained in lawful custody awaiting trial shall not continue to be kept in such detention for a period longer than the maximum period of imprisonment prescribed for the offence

Section 35(1)(e) applies more to the practice of medicine. It creates an exception to the liberty of a person to situations where such persons suffers from infectious or contagious diseases, persons of unsound mind, persons addicted to drugs or alcohol for the purpose of the patient's care or treatment or protection of the community.

It is submitted that the above provision is too narrow as it applies only in situations of infectious or contagious diseases, persons of unsound mind or those addicted to alcohol and only for the treatment and care of that person. It thus implies that personal liberty of the patient cannot be denied in any other health situations which the doctor or the parent or family of the patients see as necessary for the sound health of the patient.

Furthermore, even in the area of restricting the liberty of a patient for treatment and care in the interest of the community, it is only the Federal government that has the power to

quarantine such patient. States do not have such powers as it is contained in exclusive legislative list of the Federal Government of Nigeria[159].

More so, the guaranteed right to personal liberty may cause problems for the practice. This is particularly the case in Nigeria's current security situations where kidnapping seems to be prevalent. Thus, a surgeon, whose patient is kidnapped in his hospital, may render himself liable in negligence or conspiracy to commit an offence under the law. Thus, the law does not provide for any special protection to medical practitioners in this regard. While the researcher is not attempting to provide a wide enjoyment of liberties to the medical practitioners to be careless about patient's right to liberty, the law should balance this situation to protect the practitioners from unwarranted litigations or prosecutions. More so, the practitioners can themselves be kidnapped in the course of their duties, thereby affecting their own right to personal liberty. This calls for the surgeon's diligence and alertness in his care for his patients by ensuring adequate surveillance, supervision and protection of his patients. Any surgeon, who falls short of this duty of care, is likely to end up in litigation for negligence or prosecution for conspiracy to commit anoffence to wit-kidnapping.

The right to self-determination is also an area that can impact negatively on health of the people or medical practice. Although this right is not expressly provided for in Nigeria in relation to the practice of medicine, the right to freedom of thought and conscience as well as freedom to hold opinions as contained in *Sections 38(1) and 39(1)* can be used in this regard. In this context, a patient may claim to have the right to do what he/she pleases with his/her own body and thusmay not want to be treated for an ailment. The patient may also hold an opinion that he does not want to be given injection by virtue of his right to

[159] . *Item 54, 2nd Schedule, Part 1 of the CFRN, 1999.*

conscience as a *Jehovah* witness.[160] So, he is entitled to his right to freedom of belief, conscience, and to hold opinions.

The Nigerian state which is still ravaged by staggering number of preventable deaths and plagued by different diseases which have been successfully tamed in many countries, where the health of the citizens is considered paramount. Jide Ojo, a Development Consultant, lamenting on the poor health situation in Nigeria, gave what he termed a dreadful score card and he said almost 800,000 Nigerian children die every year before their fifth birthday, making Nigeria the country with the highest number of new born deaths in Africa[161]. An estimated 500,000 women die each year throughout the world from complications of pregnancy and child birth; 55,000 of these deaths occur in Nigeria. Nigeria is only two percent ofthe world's population but accounts for over 10%[162] of the world's maternal deaths in child birth and ranks second globally to India in number of maternal deaths.

3.1.2 Medical and Dental Practitioners Act [163]

The Nigerian Medical and Dental Practitioners Act (MDPA) was established in 1963 to regulate the practice of Medical and Dental practitioners in Nigeria. *Section 1* of the Act established the Medical and Dental Practitioners Council of Nigeria (the Council). *Section 2* of the Act gave the Council responsibilities including determining the standard of knowledge and skill to be attained by persons seeking to become members of the profession, preparing from time to time a statement as to the code of conduct which it considers desirable for the practice of the profession in Nigeria etcetera and other such functions conferred on the

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160. *Tega Esabunor & anor v Dr. Tunde Fayewa & ors. LER [2019]SC.97/2009*

161. J. Ojo, *The non-implementation of Nigeria's National Health Act*, <https://punchng.com/non-implementation-nigerias-national-health-act/> Accessed 07/10/2022.

162. A non profit international Organization where Jide Ojo, a development consultant gave lectures, in: J. A. Dada'sbook; Legal Aspect of Medical Practice Second Edition 2013

163. *Nigerian Medical and Dental Practitioners Act Cap M8 LFN 2004*

Council by the Act. It is in line with this that the Council had established the Medical and Dental Practitioners Code of Medical Ethics (Code of Medical Ethics)[164]. The Code of Medical Ethics among other things "requires medical doctors to preserve life whenever possible, to hold in confidence communications with patients, to be honest with patients, to put professionalism above profit making[165]." The Code of Medical Ethics deals specifically with professional misconduct and not rights of the citizens to health care. It addresses issues more from the perspective of those professions which it regulates rather than from a citizens rights perspective. For example, a medical doctor found guilty of professional medical negligence which resulted in permanent disability or even death would only face the Medical Tribunal for medical negligence and if found guilty would either have his name struck off the register or suspended for a period not exceeding six months[166]. The victim is not covered by the Act and would have to fall back to civil action under torts of negligence.

The council is charged with the responsibility of disciplining erring members of the profession for professional misconduct through the Medical Disciplinary Tribunal (Medical Tribunal) established under *Section 15* of the MDPA. The Medical Tribunal has the status of a high court of the Federal Republic of Nigeria[167]. The Medical Tribunal shall consist of the chairman of the Council and ten other members of the Council appointed by the Council two of whom must be fully registered Dental Surgeons[168]. The Council also appoints members of the investigation panel established under *Section 15* of the Act. The

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[164] . See the Code of Medical Ethics in Nigeria (Code of Medical Ethics) Retrieved on 02/05/2022 from <http:/elearning.trree.org/pluginfile.php/623/mod_folder/content/0/3_2-CodeOnMedicalEthics.pdf?forcedownload=1> last accessed 02/05/2022.

. C.E. Onuabia, (2012).*The Rights of Patients in Nigeria* Available at <www.dailytimes.com.ng/opinions/rights-patients-nigeria> *Accessed on 12/06/2022*

[166] . Paragraph 30 Code of Medical Ethics

[167] . Para 2 (b) of the Medical Code of Conduct

[168] . Section 15 (2) MDPA

Investigation panel is charged with the responsibility of conducting a preliminary investigation into any case where it is alleged that a registered person had misbehaved in his capacity as a medical practitioner or a dental surgeon or should for any other reason be the subject of proceeding before the disciplinary tribunal.[169]

Section 16 (1-2) provides:[170]

Where a registered person is adjudged to be guilty of infamous conduct in any professional respect; or a registered person is convicted, by any court of law or tribunal in Nigeria or elsewhere having power to impose imprisonment, for an offence whether or not an offence punishable with imprisonment which in the opinion of the disciplinary tribunal is incompatible with the status of a medical practitioner or dental surgeon, as the case may be the Disciplinary committee may give a direction:

a. Ordering the registrar to strike out the person's name off the relevant register or register's; or

b. Suspending the person from practice by ordering him not to engage in practice as medical practitioner or dental surgeon as the case may be for such period not exceeding six months as may be specified in the directives; or

c. Admonishing that person.

The Act had not defined "infamous conduct" and had thus given the Council discretion as to what constitute misconduct and the nature of the penalty to an erring professional. A medical or dental practitioner could commit a serious offence and the council may decide to just admonish him or to even let him go scot free.

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169. Section 15 (3) *Ibid*
170. Section 16 *Ibid*

Again, a person found guilty of infamous conduct has a right by the Medical Tribunal to appeal to the Court of Appeal. Such an appeal would act as a stay to any directives of the Medical Tribunal. In such instances the said person would go on practicing medicine until after the determination ofthe appeal.

Also, despite the responsibility of the Council to review and prepare a statement as to the Code of Conduct which the Council considers desirable for the practice of the professionin Nigeria, it has failed to widen the scope of infamous conduct used in the Act to coverother emerging misconduct or misbehaviors by the medical professional it seeks to protect. For example delay in diagnosis, emergency treatment, prompt referral and other sharp practices employed by medical professional[171].

3.1.3 The Nigerian Criminal Code Act.

Criminal law obviously applies to Health Care Providers. One of the purposes of criminal prosecution is to punish the offender. There are two codes regulating criminal law in Nigeria. While the criminal code applies to the Southern States, the Penal code applies to the Northern States. Both Codes contain similar provisions under *Sections 303 & 343(1) (e)* of the Criminal Code which cases of surgical negligence may be charged. The focus will be on Criminal code.

Also, states have domesticated the codes to form criminal law in the states. Under the criminal code, any death that results from surgical negligence could be either murder or manslaughter[172]. Under the penal code, it could be culpable homicide punishable with death

[171] . N. Jamo*, Penal Sanction as A Stimuli for Health Care Delivery System in Nigeria,* (2003). *ABUJELMASVol. 5 No. 1 p 176.*

[172] . *Criminal Code Act, Cap. C38, Laws of the Federation of Nigeria, 2004*

or culpable homicide not punishable with death[173]. This shows that a surgeon or any doctor may be criminally liable for an act or omission which has resulted into the death of a patient. This means that a medical practitioner (be it a doctor or a nurse) may be criminally liable if his negligence surpasses a mere matter of compensation as to amount to a crime against the state[174].

In a situation where Health-Care Providers in their practices become grossly negligent causing bodily harm, or reckless in the care of others, they will be liable in criminal proceedings. Both the Criminal and Penal Codes provide sanctions for criminal negligence. For instance, *Sections 303 & 343(1) (e)* of the Criminal Code[175] is reproduced in this thesis-thus*;*

> *"that it is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act; and he is held to have caused any consequences which result to life or health of any person by reason of any omission to perform that duty".*

On the other hand, *Section 343(1) (e-f)* of the Code[176] provides that any person who in a manner as rash or negligent as to endanger human life or to be likely to cause harm to any person:

(e) gives medical or surgical treatment to any person whom he undertakes to treat; or

(f) Dispenses supplies, sells, administers, or gives away any medicine, or poisonous or dangerous matter; is guilty of a misdemeanor, and is liable to imprisonment for one year[177].

While this section creates the offence of misdemeanor for negligent act which only

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[173]. *Penal Code (Northern States) Federal Provisions Act, Cap P3, Laws of the Federation of Nigeria, 2004*

[174]. This is the legal position in the case of See *R vs. Bateman (1925) 133 L.T. 30 at 732, (1925) 133 L.T. 30 at 732,*in Okonkwo and Naish , *Criminal Law in Nigeria,* Ibadan, Spectrum Books Ltd, 2003, p. 250

[175]. *Sections 303 and 343* (1) &(E) of the Criminal Code of Nigeria

[176]. *Sections 343 (1)* of the Criminal Code of Nigeria

[177]. *Ibid*

endangers human life or is likely to cause harm to another person, *Section 303* creates the offence of manslaughter for gross negligent acts which cause death. Therefore, the punishment in criminal proceedings instituted against a Health Care Provider may be imprisonment or fine or both. So long as negligence, whether it causes death or not, is not of such a high degree or is not gross as to be sufficient to convict for manslaughter, the charge should come under *Section 343* of the Criminal Code. It is the same where an act that is grossly negligent does not result in death. Here, one cannot be convicted of manslaughter but may be conveniently convicted under *Section 343*.

From the above provision, it can be said that criminal liability of a surgeon for a negligent treatment of a patient is envisaged in the law. The surgeon owes to the patient a duty of care. This duty must not be breached. This shows that where the degree of skill, care and competence required of a surgeon is not met in a particular case, a breach of duty which may give rise to criminal liability arises. The case of *Surgeon Captain C. T. Olowu v. Nigerian Navy*[178] is illustrative here. The fact of the case is simple, the wife of a senior Naval Officer, Mrs. Joy Bassey alleged to have lost a pregnancy which later resulted in her suffering from vesico vaginal/fistula (VVF) due to the negligence of the gynaecologist, Naval Captain C.T Olowu, had filed an application before a Federal High Court in Lagos demanding for N50,000,000.00(Fifty million naira) compensation judgment. According to statement of fact filed before the court, it was alleged that the plaintiff, who is the wife of a Naval Officer, Poma Kingsley Bassey on 2 April 1999 went into labour and was rushed to the Nigerian Naval Medical Centre where she has been attending ante-natal clinic and was admitted.

[178]. *(2006)LCN/2085(CA)*

Thereafter the Gynaecologist Navy Captain C.T. Olowu, the then Captain Medical of the hospital was contacted on phone by the nurse on duty. In response he directed the plaintiff's husband to buy or donate a pint of blood before his arrival which the plaintiff's husband did.

However it took Captain Olowu 8-9 hours to attend to the plaintiff. He instructed the nurse on duty to take care of the plaintiff's treatment and went away and left her at the mercy of the nurse who could do little or nothing to handle the plaintiff's precarious condition. Consequently, the plaintiff was abandoned till the following day and when Captain Olowu finally came he wrote a referral letter to the Nigerian Army Base Hospital, Yaba, Lagos where the plaintiff was taken to at the point of death.

The plaintiff was formally informed two months later by Dr. I.E. Nwakor that not only did she lose her baby but her womb and her bladder were badly damaged and she now suffers from Vesico Vaginal Fistula VVF due to the gross negligence of the defendants. For over a period of two and half years, nothing was done by the Naval authorities towards remedying the plaintiff's condition and her health was deteriorating daily. Therefore she was left with no other option than to seek legal redress to bring to the attention of the Naval authorities the unfortunate injustice meted out to her. A medical board was subsequently set up, a test was conducted and the result from Ojo barracks laboratory and the medical report from the late Colonel I.E. Nwakor of Military Hospital, Ikoyi, proved to the board the recurrent bouts of urinary tract infection suffered for years. The costly drugs prescribed and the money spent was borne by the plaintiff.

After series of correspondences from the plaintiff's lawyer, she was recommended for overseas medical treatment after she was sent to Colonel Okafor in Nigerian Army Base

Hospital, Yaba for a comprehensive medical report that was referred to the doctor in Assuta Hospital in Israel.

She was finally sent to Israel on 19 February 2004, but there was no comprehensive medical treatment for her. She went to the Nigerian Embassy to complain and the Nigerian Navy agent Mr. Rave Yaran who was forced by the embassy to pay for some of her test said no money was sent for her treatment.

The plaintiff on returning to Nigeria wrote a report of how she was treated by the Israeli agency and sentit to the Naval authorities and attached the medical report and recommendation from Dr. Kaline, head of Ob-Cyn Unit, Assuta Hospital. But the said report was ignored.

The plaintiff contended that her situation has caused the eventual breakdown of her marriage and she can no longer afford the cost of drugs.

Apart from the above scenario, a surgeon could also be liable for murder or manslaughter depending on the circumstances of each case. This means that where a surgeon has negligently caused the death of a patient, such a surgeon may, upon conviction be sentenced to death or life imprisonment for manslaughter as the case may be. Therefore, if a Health Care Provider does not use reasonable care, or his conduct falls below the standard of care required by law, he is said to be negligent. This implies that if a surgeon does not use reasonable care or he negligently performs his duties and thereby causes the death of a patient, he is guilty of manslaughter. However, his negligence or incompetence must be so great as to show a disregard for life and safety and to amount to a crime against the state and

conduct deserving punishment. That is, the degree of negligence must be a gross one. The most frequently quoted statement on this aspect of the law is the *dictum of Lord Hewart* in the English case of ***R. v Bateman***[179] where his lordship said, in explaining to the *juries* the test which they should apply to determine whether the negligence, in the particular case, amounted to or did not amount to crime, the judges have used many *epithets*, such as culpable, criminal, gross, wicked, clear, and complete. But, whatever, epithet be used, and whether an *epithet* be used or not, in order to establish criminal liability, the facts must be such that, in the lawyer's opinion, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disrespect for life and safety of human beings which could give rise to a crime against a state and behavior worthy of punishment.

It should be pointed out that neither the Criminal Code nor the Penal Code provides the requisite degree of negligence that is required to sustain the conviction of murder or manslaughter in a case of medical negligence. This is a weakness on the part of the law as legal uncertainty is created in this situation. The above English case is of mere persuasion in Nigeria's criminal jurisprudence. The nature of this form of offences deserves more legal clarity or certaintyso as not to leave the matter to the use of discretion by the courts.

As a result, the degree for liability, required of medical practitioner should be that of gross and not simple negligence. In ***Kim v State***[180], the Supreme Court held that the degree of negligence required in the medical profession to render a practitioner liable for negligence is that it should be gross and not mere negligence. Also, the court cannot however transform negligence of a lesser degree into gross negligence by giving it that appellation. The court

179. *(1925) 133 L.T. 30 at 732*
180. *[1992] 4 NWLR (Pt. 233) p. 17*

referred to and followed the case of *Akerele v R*[181]. Here, the accused, a qualified medical practitioner, administered injections of a drug known as *Sobita* to children as a cure for *yaws*. A number of children died and he was charged with manslaughter of one of the children. The case of the prosecution was to the effect that the accused had concocted too strong mixture and thereby administered an overdose to the deceased, amounting to gross negligence. He was found guilty of manslaughter and sentenced to imprisonment for 3 years. WACA upheld the conviction, but the accused further appealed to the Privy Council which held that the accused negligence did not merit to be gross negligence and appeal was allowed. The court reminded the counsel that what is required is for the negligence to be gross and neither the jury nor the court can transform anything lesser or higher about it.

The use of criminal law in the medical context has been seriously questioned. For instance, it was argued that carelessness, incompetence and error should not, save in exceptional cases, be the business of the criminal law. However, it should be noted that since majority of offences arise from carelessness and error, there is nothing out of place using criminal law to regulate medical practice. This is because *Section 24* of the Criminal Code provides that no person can be criminally responsible for his unwilled acts or omission or express provisions of the Code relating to negligent acts or omission. This analysis shows that for a criminal conviction of manslaughter for a surgeon/or other medical practitioners to hold, there must be a gross negligence[182].

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[181] . *[1942] 8 WACA 5*

[182]. For instance, in the period 1970-1990, there were four prosecutions recorded in the U.K. Hospitals, from 1990- 1999, there were seventeen, but from 2000-2006, there appear to have been sixty-four. Since the Corporate Manslaughter and Corporate Homicide Act, 2007, an NHS Trust person could be convicted of manslaughter if the way the Trust was run negligently, caused death.

The decision in the case of *Akerele vs. R*[183] represents the position in Nigeria. This decision is in line with *Section* 303 of the Criminal Code which provides that every person, except in cases of necessity who undertakes to administer surgical or medical treatment, has a duty to have reasonable skill and to use reasonable care in administering the treatment. However,possible defenses might be available in *Sections 297 and 313* of the Criminal Code. *Section 297* provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit if the performance of the operation is reasonable having regard to the patient's state at the time and to all circumstances of the case. However, if negative consequence has caused the death of the patient as a result of this breach of the duty to take care, a surgeon will be held to have caused such consequence[184].

It is trite law, therefore, that performing an emergency surgery in the absence of proper indications and justifications is negligence. An anesthetist was found guilty of manslaughter where he caused the death of a patient due to his gross negligence in attention during surgery[185]. Thus, a surgeon owes to his patient or client a duty of care not to act negligently.

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[183]. *[1942] 8 WACA 5*

[184] . The case of *Dr. Conrad Murray v Michael Jackson is a case in which* Dr. Conrad was found guilty of gross

negligence in the surgery he performed on Michael Jackson the late famous musician, without reasonable skill and care in performing the cosmetic operation which resulted to his death. The court of first instance found for MichaelJackson while both the Appeal Court and the Supreme Court confirmed the guilt in negligence.

[185] . See *R. v Adomako* [1944] 3 All E. R. 78 (HOL, England). In this case, the defendant anesthetist failed to notice

that a tube supplying oxygen to the patient (who had been paralysed for the operation) had become disconnected from a ventilator during an eye operation. The disconnection lasted for some six minutes without the notice of the anesthetist, and the patient suffered a cardiac arrest from which he subsequently died. Two expert witnesses gave evidence for the prosecution and one described the standard of care by the defendant as 'abysmal.' The other witness stated that a competent anesthetist should have recognized the signs of disconnection within 15 seconds, andthat the defendant's conduct amounted to 'a gross dereliction of care. On this note, Lord Mackay stated that a finding of gross negligence would depend on the

This is so whether or not there is an agreement between them. He must possess a reasonable skill and use the skill in every case. In the case of *R. vs. Inner South London Coroner,* ex p *Douglas- Williams*[186], the Court was able to set out the requirements for a gross negligence.

They are:

(i) Negligence consisting of an act or failure to act,

(ii) That negligence must have caused the death in the sense that it was more than minimally, negligibly or trivially contributed to the death; and

(iii) The degree of negligence has to be such that it can be characterised as gross in the sense that it was of an order that merits criminal sanctions rather than a duty merely to compensate the victim.

Similarly, *Sections 311 and 326*[187] of the Criminal Code prohibit *Euthanasia* (killing oneself) in whatever form(s) (either through the counseling of the surgeon, procuring or aidingit).

Section 311 provides that A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is laboring under the same disorder or disease arising from another cause, is deemed to have killed that other person. Equally, *Section 326* says Any person who: (i) procures another to kill himself; or (ii) counsels another to kill himself and thereby induces him to do so; or (iii) aids another in killing himself; is guilty of a felony; and is liable to imprisonment for life.

The combined effect of the above provisions shows that aiding a patient towards killing himself is illegal in Nigeria and no surgeon has a right to terminate the life of any patient or

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seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred

[186]. *(1999) 1 ALL E.R. 344*

[187]. *Criminal Code of Nigeria*

help to terminate the life of a patient. Where he does, he will be liable to criminal prosecution which may attract life imprisonment or death sentence.

It must be pointed out that the requirement of the law stated by Douglas-Williams in the case above puts some clarity to what gross negligence entails. However, as earlier stated, this case, being foreign in nature, only has persuasive effects on local courts. So, the Criminal Code can be amended in this aspect in line with requirement with such modification as may be necessary and debated by law makers in order to better serve the interest of justice and ensure clarity in justice dispensation.

3.1.4 The Code of Medical Ethics in Nigeria Cap 221, LFN 1990

The Medical and Dental Practitioners Act[188] now LFN 2004 provides for the establishment of the Medical and Dental Council of Nigeria hereinafter called the Council. *Section 1(2)* (c) of the Act provides for the statutory functions of the Council principal among which is reviewing and preparing from time to time a statement as to the code of conduct which the Council considers desirable for the practice of the profession in Nigeria.

Section 2 (d) (e) of the Medical and Dental Practitioners Act[189] empowers the Medical and Dental Council of Nigeria to oversee, control and supervise the practice of customary medicine, homeopathy and other kinds of alternative medicine in Nigeria. Pursuant to the enabling law, the Medical and Dental Council of Nigeria has been constituted in accordance with the provision of the law. The statement on the Code of Conduct which the Council considers desirable for the practice of the profession in Nigeria has been prepared and reviewed from time to time. It was first titled Rules of Professional Conduct for Medical and

[188]. Medical and Dental Practitioners Act (Decree No. 23 of 1988) Now LFN 2004

[189]. Medical and Dental Council of Nigeria to Oversee Control and Supervise the practice of customary Medicine.

Dental Practitioners in Nigeria but later titled CODE in consonance with its legal status[190]. The Council wishes that every Medical and Dental Practitioner should acquaint himself or herself with the provisions of the Code so that he or she would practice the profession with conscience, dignity and within the provisions of the Code. This will bring incidences of ethical breaches or violations to the barest minimum as ignorance of law admits no excuse.

Compliance with the code will enhance the image of the profession; increase the confidence of the public in the practitioners and offer protection to the conscientious practitioners.

Considering the paucity of books on medical ethics here in Nigeria, this code also serves as information booklet for Medical Students, Medical Teachers, Legal Practitioners who are engaged in Medical Jurisprudence and even Laymen and Patients who may be obliged to seek information on these aspects of medical and dental profession in Nigeria. The Code of Medical Ethics in Nigeria was revised in 1995 and a new edition has been published as Code of Medical Ethics in Nigeria since 2004. It is divided into eight parts as follows:

Part A of the Code contains *Sections 1-24* which deals with preamble and general guidelines, which include: the objective of the rule, induction of newly qualified medical or dental practitioners into the profession, Declaration and Oath, Registration, payment of practicing fees and annual license, guidelines for non-indigenous medical and dentalpractitioners, clinic *etiquette*, self-medication by registered practitioners, professional services to colleagues, telemedicine, management of *HIV/AIDS* and other socially dreaded diseases.[191]

Part B of the Code contains *Sections 25-31* which deal with professional conduct,

[190] . MDCN, <https://www.mdcnigeria.org/downloads/code-of-conducts.pdf, accessed 25/05/2022.

[191] . MDCN, <http:/www.mdcnigeria.org/ethical%2520cond also www.mdcnigeria.org/mandateframe.htm.>, accessed 25/05/2022

professional brotherhood of good repute and competency, professional negligence and so on.[192] Part C of the Code contains *Sections 32-39* which deals with malpractices in general respect, deceit of patient to extort fees and service charges, aiding and abetting unprofessional practice of medicine and dentistry and so on.

Part D of the Code contains *Sections 40-48* which deals with improper relationship with colleagues or patients, instigation of litigation, case referrals to colleagues, movement of patients among practitioners, confidentiality and adultery or other improper conducts or association.[193]

Part E of the Code contains *Section 49-53* which deals with aspect of private practice, decency and decorum in professional transactions.

Part F of the Code contains Sections *54-59* which deals with self-advertisement or procurement of advertisement, media publication of pending treatment, media publicity, touting and canvassing, signboards and sign posts.

Part G of the Code contains Sections *60-62* which deals with conviction for criminal offences which include abortion, aiding criminals in clinics or hospital premises, conviction of a registered practitioner in a court of law.

Part H of the Code which is the last, but not the least contains *Sections 63-75* which deal with miscellaneous items such as alcohol, drugs, improper financial transaction (fraud), Torture, *Euthanasia*, fitness to practice and enforcement of sanctions.

Medical Practitioners are duty bound to comply with the foregoing Codes of Medical Ethics or face sanctions for ethical breach:

The *Hippocratic Oath* is perhaps the most widely known of *Greek* medical texts. It requires a

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192. *Ibid*

193. MDCN, <http:/www.mdcnigeria.org/ethical%2520cond also www.mdcnigeria.org/mandateframe.htm.>, accessed 25/05/2022

new physician to swear upon a number of healing *gods* that he will uphold a number of professional ethical standards. It also strongly binds the student to his teacher and the greater community of physicians with responsibilities similar to that of a family member. In fact, the creation of the Oath may have marked the early stages of medical training to those outside the first families of *Hippocratic* medicine, the *Asclepiads of Kos*, by requiring strict loyalty.

Over the centuries, it has been rewritten often in order to suit the values of different cultures influenced by Greek medicine. Contrary to popular belief, the *Hippocratic Oath* is not required by most modern medical schools, although some have adopted modern versions that suit many in the profession in the 21st century. It also does not explicitly contain the phrase; First, do no harm which is commonly attributed to it.

3.1.5 The Medical Oath

Prospective Medical and Dental Practitioners being inducted to practice in Nigeria are required to publicly declare their readiness to obey professional rules and regulations thus:

I, Dr. XYZ do solemnly and sincerely declare that as a registered medical/dental practitioner of Nigeria, I shall exercise the several parts of my profession to the best of my knowledge and ability for the good, safety and welfare of all persons committing themselves to my care and attention and that I will faithfully obey the rules and regulations of the Medical and Dental Council of Nigeria and all other laws that are made for the control of the Medical and Dental profession in Nigeria.

In addition to the Declarations mentioned above, the Medical and Dental Practitioners in Nigeria are made to subscribe to the PHYSICIAN OATH which is reproduced as follows:

I (Dr) XYZ SOLEMNLY PLEDGE to consecrate my life to theservice of humanity;
I WILL GIVE to my teachers the respect and gratitude which aretheir due;
I WILL PRACTICE my profession with conscience and dignity; THE HEALTH OF MY PATIENT WILL BE my first consideration; I WILL RESPECT the Secrets which are confided in me even afterthe patient has died;
I WILL MAINTAIN by all means and in my power the honour and the noble traditions of the medical/dental profession;

My COLLEAGUES WILL be my brothers and sisters;
I WILL NOT PERMIT consideration of religion, nationality, race, party politics or social standing to intervene between my duty and my patients;
I WILL MAINTAIN the utmost respect for human life from the timeof conception.
Even under THREAT I WILL NOT USE my medical knowledge contrary to the laws of humanity.
I MAKE THESE PROMISES SOLEMNLY, FREELY and upon my HONOUR.

The foregoing is also referred to as the Declaration of Geneva (Physician Oath Declaration) adopted by the General Assembly of World Medical Association at Geneva, Switzerland in September 1948 and amended by the 22nd World Medical Assembly at Sydney Australia in August 1994.[194]

The above Physician Oath is the modern version of what is popularly called the Hippocratic Oath which is the foundation of the code of medical profession[195]. The signature of the doctor or dentist taking oath is appended and it is also dated appropriately. Every medical practitioner in Nigeria is thus expected to be guided by the code of professional ethics as complemented by the combinations of the Declaration and the Physician Oath in the performance of his professional responsibilities. Every member of the medical profession must abide by the dictates of the physician's oath. Embodied in this oath are the guidelines for behavioural interaction between practitioners and their patients; practitioners and their teachers; as well as practitioners and the public as represented by the law and the government.[196]

Fundamental to these ethical guidelines is an ALLEGIANCE which every doctor or dentist mandatorily owes to the corporate body of the profession. This corporate body of the

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194. Declaration of Geneva 1948 <https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/decl-of-geneva-v1948/> accessed 27/05/2022

195. Hippocrates 1760-337, a Greek man and the greatest physician of antiquity regarded as the father of medicineHippocratic Oath is the Physician Oath of today.

196. Declaration of Geneva 1948 <https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/decl-of-geneva-v1948/> accessed 27/05/2022

profession by traditional practice or convention through the ages has assumed the responsibility for maintaining and constantly enhancing the standard of services provided to the public as well as protecting the profession from unwarranted incursions by quacks.

The legal implication of any ethical breach depends on the circumstances of each case. While some ethical breach would amount to commission of crime, others amount to civil wrong, while again, others are neither here nor there. Where ethical breach constitutes a known crime, the culprit either gets acquitted or convicted in the regular court of law. Where the ethical breach constitutes a civil wrong, the aggrieved gets compensatory damages for the injury suffered.

3.1.6 The Nursing and Midwifery (Registration etc) Act 1979

Nursing and Midwifery as a profession, encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all setting. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. It encourages and promotes safe environment, research, participation in shaping health policies, in clients and health systems, management and education are also key nursing roles[197] .

Nursing is the protection and optimization of health and the abilities; prevention of illness and injury; alleviation of suffering through diagnosis and treatment of human responses; and advocacy in health care for individual families, communities and population[198] . The uses of clinical judgment in the provision of care to enable people to improve, maintain, recover or cope with health problems, and to achieve the best possible quality of life, whatever is the

[197] . International Council of Nurses, 2007.

[198] . ANA considering Nursing, American Nurses Association, retrieved May, 2022.

disease or disability, until death[199] .A Nurse is a person who cares for the sick, wounded, or enfeebled, especially one who makes a profession of it[200].

The Nursing and Midwifery Profession is regulated by Nursing and Midwifery Council (Registration etc) Act of Nigeria, Laws of Federation of Nigeria Cap 143[201]. Also, Midwife is a woman who assists women in delivery and midwifery is *obstetrics*[202]. *Obstetrics* is a branch of medical science relating to pregnancy and childbirth; midwifery[203]. The Midwife has a statutory duty to patient and a midwife in charge of a case of labour shall under the Act comply with the provisions of this regulation[204]

Duties of midwife in charge of a case of labour.

1. The midwife shall not leave the patient without giving an address at which she can be reached without delay[205] .
2. After the commencement of second stage of labour, the midwife shall stay with the patient until the expulsion of the *placenta* and membranes and for as long a time as may be necessary[206] .
3. In a case where the labour is abnormal or there is threatened danger, the midwife shall send for a doctor or have a doctor sent for and she shall await the arrival of the doctor and faithfully carry out his instructions[207] .

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[199]. Royal College of Nursing, 2003, retrieved 22/05/2022

[200] . The New International Webster's Comprehensive Dictionary of the English Language, Encyclopedic Edition, Trident Press International, Florida, U.S.A, p.869

[201] . Nursing and Midwifery (Registration etc) Act. Council of Nigeria, 2011

[202] . The New International Webster's Comprehensive Dictionary of the English Language, Encyclopedic Edition, Trident Press International, Florida, U.S.A, p. 807.

[203]. *Ibid*, p. 873

[204]. Nursing and Midwifery Council (Registration etc) Act, Cap. 143, Laws of Federation of Nigeria.

[205]. *Section 27(1)*

[206]. *Section 27 (2)*

[207]. *Section 27 (3)*

4. If for any reason when a doctor is sent for, the services of a registered medical practitioner are not available, the midwife shall, if the case may be one of the emergency, shall remain with the patient and to do her best for her until the emergency is over[208] .
5. Having complied with provisions of paragraph (4) (as to the summoning of medical assistance) of this regulation, the midwife shall not incur any legal liability by remaining on duty and doing the best she can for her patient if the services of a registered medical practitioner are not available.
6. A midwife shall not, except in a case of grave emergency, undertake operative work or give treatment which is outside her province as a midwife.
7. Where a midwife, in a case of grave emergency, undertakes such work or gives such treatment, she shall forthwith inform the local supervisory authority.
8. The question whether, in any particular instance, such work or treatment was justified shall be judged on the facts and circumstances of the case[209].

Section 28 (1)(a) – (d) of the regulation, provides that the midwife shall wash the genital parts of the patient's body with soap and water and then swab them with an antiseptic lotion on the following occasions; before making all internal examinations; after the termination of labour; before passing a *catheter,* and after bowel action.

Subsection (2) of that section further provides that "the swabbing with antiseptic lotions shall be repeated before each further examination and before a douche is given and for this purpose the midwife shall use material which has been boiled or otherwise disinfected before use".

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[208]. *Section 27 (4*)
[209]. *Section 27 (6) – (9)*

Section 29 provides that internal examination during labour shall be restricted to the absolute minimum, while *Section 30* provides that the midwife in charge shall in all cases of labour examination, examine the *placenta* and membranes before the disposal thereof and shall satisfy herself, that they are completely removed. The midwife shall remove soiled linen, blood, feces. Urine, *placenta* and membranes from the neigbourhood of the patient and from the *puerperium* room as soon as possible after the labour and in every case before she leaves the patient[210] .

In Nigeria, there is a code of conduct and rules that control the practice of Nursing and Midwifery as a profession. The check and balances in the Medical Health Care in Nigeria and all her practicing professionals are enjoined to practice strictly under the legal regime in Nigeria, viz, Nursing and Midwifery (Registration etc) Act and Medical and Dental Practitioners Act.

Nursing and Midwifery (Registration etc) Act - *Section 1 (1*) – provides "that there is hereby established a body to be known as the Nursing and Midwifery Council of Nigeria (in this Act referred to as the 'the Council' which shall be a body corporate with perpetual succession and a common seal and may sue and/or be sued by the name aforesaid." *Section 2* of the same Act – provides that the Council shall be charged with the general duty of –

a) Determining what standard of knowledge and skill are to be attained by persons seeking to become members of the profession of nursing and midwifery (in this Act referred to as "the profession") and reviewing these standards from time to time as circumstances may require;

[210] . *Section 31*

b) Securing in accordance with the provisions of this Act the established and maintenance of the register of persons entitled to practice the profession and publication from time to time of the list of persons;

c) Regulating and controlling the practice of the profession in all within the profession;

d) Maintaining in accordance with this Act of discipline within the profession; and

e) Performing the other functions conferred upon the Council by this Act.

Section 3 – Subject to *subsection (4)* of this section and to any direction of the Minister under this Act, they shall have power to do anything which in its opinion is calculated to facilitate the carrying on its activities.

Section 4 The Council shall not have power to borrow money or to dispose any of the property except with the prior consent of the Minister and shall not have power to pay remuneration (including pensions) allowances or other expenses to any member or employee of the Council or to any other person except in accordance with the scales approved after consultation with the Federal Civil Service Commission. Nigerian Nurses and Midwives must act in line with the Law or the Act creating their profession with other related Medical Health Care personnel/officers in providing health care to individuals, groups and communities; also bring to bear on nursing and midwifery practice in other roles, such as leadership, education and/or researches.

Under *Section 18* (1) of this Act *Section 1* - provides that subject to any restriction upon registration otherwise imposed by this Act, the holder of: (a) any qualification of a general nature specified in part A of the Second Schedule to this part; (b) any qualification of a specialized nature specified in Part B of the second schedule to this Act, - shall be entitled to

registration as a nurse in the appropriate part of the general register maintained pursuant to *Section 6(2)* of this Act.

Section 2 - A registered nurse may apply for registration as a nurse tutor upon the ground that she has undergone requisite practical training in an institution where student nurses are trained and has completed a course for nurse tutors in an institution or university recognized for that purpose by the Council, and if the Council is satisfied as to his qualification, the Council may direct registration accordingly.

Section 9 (1) – an applicant for registration shall, unless otherwise precluded by the Act, be entitled to registration as a midwife if she satisfies the Council that she is of good character and – (a) is the holder of a certificate under Part B of the Second Schedule to this Act; or (b) is exempted from examination as the holder of a qualification granted outside Nigeria and for the time being accepted by the Council; Provided that if the Council so requires, the applicant shall satisfy the Council that she has sufficient practical experience as a midwife. *Sub - section 2* – that any person aggrieved by the decision of the Council under this section may appeal to the High Court most convenient in terms of access to her, within one month after notice is given to her of the decision of the Council.

As a registered and licensed nurse and midwife, who had successfully gone through the *Sections 8 and 9* of the Nurses and Midwifery Council of Nigeria, Cap 143, Laws of Federation of Nigeria, they are enjoined to register and renew their registration, also that any applicant must be committed to uphold the standards therein contained in the said Act. This commitment to professional standards and etiquette as required by the law for every registered and licensed nurse and midwife is a mandatory requirement, meaning that an

action would be taken against the registered and licensed nurse and/or midwife, if he or she fails to uphold the ethics of the profession or thereby commit any wrong or crime most unprofessional in such a manner or conduct to be described as an infamous conduct, is a serious offence that could lead to striking out the name of the offender from the register.

Section 18 (1) – provides that where –

a. A person registered under the Act is convicted by any Court in Nigeria or elsewhere having power to award imprisonment for an offence which in the opinion of the Tribunals is incompatible with the status of a nurse or midwife; or

b. Registered person is judged by the a Tribunal to be guilty of infamous conduct in a professional respect or

c. The Tribunal is satisfied that any person has been fraudulently registered, the Tribunal may, if it thinks fit, give a direction –

(i) reprimanding that person; or

(ii) ordering the registrar to strike his/her name off the relevant part of the register; or

(iii)suspending him from practice by ordering him/her not to engage in practice as a nurse or midwife for such period not exceeding six months as the case may be specified in the direction;

and any such direction may, where appropriate, include provision requiring refund of moneys paid or the handing over of documents or any other thing in the circumstances, as the case may require. As a registered and licensed nurse and/or midwife one would be professionally and legally accountable for his/her actions and omissions, irrespective of whether he/she is following the instructions of another or using his or her initiative. Medical Health Care litigation is growing and patients are increasingly growing to assert their rights. A thorough

and critical appreciation of the legal, ethical and professional issues affecting nursing and midwifery practice is essential, in order to develop the professional awareness necessary to escape the hazards of the profession, also its demand are on the student nurses, practicing nurses and the midwives to practice in accordance to the ethical and legal framework that ensures the privacy of the patients and their interest.

3.1.7. THE NATIONAL HEALTH ACT 2014

The importance of health and the right to health is as paramount as the right to life, hence it serves as a key indicator of sustainable development[211]. It is in the light of the foregoing that the National Health Act was first proposed in 2004[212] and enacted in 2014.

The National Health Act 2014 is a legal framework for the regulation, development and management of the Nigerian health system, with the purpose of advancing the promotion and protection of same. It thus provides the legal standards for administering health services and other related matters in Nigeria.

Sections 20-30 of the National Health Act 2014 provides for the rights and obligations of health care users and healthcare personnel particularly on emergency treatment, rights of health care personnel, indemnity of healthcare provider, knowledge to health care user, duty to disseminate information, obligation to keep record, confidentiality, access to health records, protection of health records and laying of complaints. In addressing the discourse, a compendium of the sections would be addressed as a whole and not in parts.

The law of foremost necessity critically analyzed the right to health and right to life, as it provides for the attendance to emergency medical treatments, of which failure of such

[211]. *African Charter on Human and Peoples' Rights 1986, Art. 16. CFRN 1999 (as amended), Chapter 2.*

[212] . F.A Obi, The National Health Bill: After Ten Years in the Making is an End in Sight? Nigeria Health Watch 2014 accessed 12/06/2022

attracts a criminal liability[213]. In emphasizing the promotion of a sustainable medical system, the Act expresses certain guidelines, conditions[214] and indemnity clauses[215] of healthcare personnel, provider and establishment. It further behooves on the healthcare establishment or personnel to provide accurate information of services rendered to the health care user and medical authorities[216] and also provide accurate information on the health status of the healthcare user to the healthcare user[217].

This Section of discourse further exposes that the health history, information infrastructure, and the connection of privacy and protection of a patient's medical record or health data shall be considered as confidential personal data. Sensitive personal data requires special protection, and usually are protected specifically by the Act.

Unlawful disclosure, unauthorized access or abuse to health information may disclose personal and embarrassing details of patients/health care users that could lead to infringements of the individual right of privacy (intrusion, commoditization of health data, extortion and other social inequality that weakens the bond of trust between health care providers and consumers[218].

The Act implies a good policy on data governance and management to prevent unauthorized access, unlawful disclosure, data loss, and data theft – both online and offline. It prescribes the penalty of Two Hundred and Fifty Thousand Naira (N250,000.00) only as fine or a two (2) years imprisonment or both[219]. The privacy offences include falsification or alteration of

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213. National Health Act 2014 *Section 20*
214. *Ibid Section 21*
215. *Ibid Section 22*
216. *Ibid Section 24*
217. *Ibid Section 23*
218. *National Health Act 2014 Sections 25-29*
219. *National Health Act 2014 Section 29*

records, destruction of records without authority, re-identifying de-identified records, unlawful access or interception of records.

Privacy in the context of healthcare refers to the patient's right to control and keep private information about his or her health. It also involves the circumstances where protected health information may be used or disclosed to a patient. The right to privacy is a fundamental right which the Nigerian Constitution recognizes[220]. Well beyond constitutional provision and professional duty, privacy law adds another layer of legal duty and protection. The exceptions to confidentiality and privacy of a health care user medical record are consent[221], research[222], court order[223],usage by other healthcare provider[224].

Put succinctly, the above sections set out the rights and responsibilities of healthcare consumers, healthcare staff and healthcare establishments and provides for rights of healthcare user or healthcare personnel to lay complaint to the appropriate authority[225].

The provision on laying of complaint is of no help to medical service users in Nigeria, as the Minister or a commissioner or health authority which is a health service provider can probably devise procedures that will be more favorable to the provider other than serve the end of justice.

The Act needs to be amended to the extent that an independent body or person, not being a member of the medical profession, should make the procedure for complaint to enable the rights of patients to be well-ventilated. The importance of the right to health, right to life and the establishment of the National Health Act cannot be over-emphasized. The Act which is a

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220. *Constitution of the Federal Republic of Nigeria 1999 (as amended) Sections 37*
221. *National Health Act 2014 Section 28 (1)*
222. *National Health Act 2014 Section 28 (2)*
223. *National Health Act 2014 Section 26(2)*
224. *National Health Act 2014 Section 27*
225. *National Health Act 2014 Section 30*

right step to health development establishes the position of research or experimentation with human subject[226] and the establishment, composition, function and tenure of national health research ethics committee[227]. It provides that humans can be used as subject of research or experiment, solely upon the manner prescribed by the National Health Research Ethics Committee and upon the consent of such human and where the human is a minor or for *non-therapeutic* purpose, consent from a guardian or parent is a prerequisite for such research. It further provides for the fifteen (15) positions to be occupied by members of the Committee[228], the term of appointment[229], position of termination by death[230], and other guidelines[231]. In the interest of the health care system, the law further stipulates that tissue, blood or blood products shall not be removed from a living person, subject however to the provision of *Section 53* NHA 2014, and the informed consent of the person, except in emergencies and authorized medical necessity.

An act or a refusal of an act, that contravenes the above, shall attract a criminal liability[232]. Also, the reproduction and *therapeutica*l cloning of human kind is largely prohibited and its criminal liability is a minimum of five years imprisonment with no option of fine[233].

Summarily, the importance of health, life and medical science and its practices in the Nigeria health system and the preservation of health, birthed standards and regulations capsulated into Laws and Acts which provides for the interest of healthcare users, healthcare personnel/staff, healthcare establishments and the ministry of health. These laws extend to

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226 . *National Health Act 2014, Section 32*
227 . *National Health Act 2014, Section 33*
228. *National Health Act 2014, Section 33 (1) – (2)*
229. *National Health Act 2014, Section 33 (3) – (4)*
230 . *National Heath Act 2014, Section 33 (5)*
231. *National Health Act 2014, Section 33 (6) – (7)*
232. *National Health Act 2014, Section 48-49*
233. *National Health Act 2014, Section 50*

the protection of the public and give respectability to the profession. It is recommended that the National Health Act implementing institutions should embark on awareness campaigns to create awareness among end users of medical services, about their rights under the Act. Also, in view of the fact that the regulatory tribunal formed under the Medical and Dental Practitioners' Act is on the same level as a high court in the judicial system, it should be allowed to award compensation to victims of medical neglect. This means that this *quasi-judicial* body's actions should go beyond simply striking out the medical personnel's name from the roll. Healthcare professionals are an important component of healthcare systems as they are relevant to the provision of smooth, effective, efficient and high-quality health care services. Since the NHA aims at regulating, developing, managing and advancing the national health system in Nigeria, the role of health professionals in the actualization of the goal cannot be over emphasized.

3.1.8 The Compulsory Treatment and Care for Victims of Gunshot Act 2017

There was a time in the history of Nigeria that having a gunshot wound was a death sentence. This sentence was not imposed by a court of competent jurisdiction nor was it carried out by agents of the state. It was imposed by the presumption that every person with a gunshot wound had engaged in an illegal activity probably, armed robbery, kidnapping or burglary and had escaped after being shot by security officers in an attempt to apprehend him. Those rightly disposed to offer immediate aid ensured the death of the victim through their inaction. People, but most of all, hospitals were wary of receiving gunshot victims or rendering any form of aid to them because they did not want trouble. Against this backdrop, the Compulsory Treatment and Care for Victims of Gunshots Act, 2017 (Hereinafter referred to

as the 'CTCVG Act') was enacted to compel the treatment and care of persons who have sustained gunshot wounds notwithstanding the circumstances under which it occurred.

The foremost content of the CTCVG Act being *Sections 1 and 2* confers on victims of gunshot, a right to be treated by any hospital and a right to be taken to hospital for treatment by any person who comes in contact with them and is able to render help. The right by implication imposes a duty on both hospitals and individuals to comply with the provisions. These are however not the only requirements. When a hospital has admitted a victim of gunshot for treatment in compliance with *Section 1* of the Act, it is required to report to the nearest police station within two hours after commencement of treatment. The aim is for the police to thoroughly investigate the circumstances under which the said victim sustained the gunshot wounds[234]. Failure to comply with this provision is an offence which will upon conviction make the hospital liable to a fine of N100,000 (One hundred thousand Naira). Also, any doctor guilty of the offence is liable to a fine of N100,000 (One Hundred Thousand Naira) or a prison sentence of six months or both[235].

The Act attempted to protect aid providers by providing that a person who volunteers to genuinely aid a victim of gunshot wound is to be respected and must not to be subjected to "unnecessary and embarrassing interrogation"[236]. The victim is also accorded further protection under the Act by reason of the provision that where a person commits an offence under the Act, and as a result, the victim suffers physical, mental, emotional and psychological damage, such a defaulter is liable upon conviction to a term of imprisonment not exceeding fifteen years and not below five years without an option of fine[237].

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[234] . *Section 3 (1), (2) Compulsory Treatment and Care for Victims of Gunshot Act 2017.*
[235]. *Ibid, Section. 5*
[236]. *Ibid, Section. 8*
[237] . *Ibid, Section. 9*

Additionally, every hospital which receives a victim of gunshot is required to within 24 hours, notify his or her family members and relations if they have ascertained his or her identity[238].

The Act prohibits standing by, this means a situation where a person or security agent is handy, disposed and able to render help to a person with gunshot wound but fails to do so without any justifiable reason. Where a person is found guilty under this provision, he or she is liable upon conviction to a fine of N500,000 (Five Hundred Thousand Naira) or five years imprisonment or both[239].

Under *Section 14* of the Act, it is provided that in addition to the penalties provided by the Act, the court may make an order for the person or security agent guilty of an offence under the Act to make restitution to the victim in form of monies equivalent to the loss he or she suffered owing to the default.

The provision of *Section 1* of the CTCVG Act which mandates every hospital to render immediate and adequate treatment to a victim of gunshot without police clearance is a laudable one. This is because, it has restated the fact that police clearance was not needed to offer treatment to a victim, a factor which *hitherto* proved to be a hindrance on the part of doctors. Consequently, lives would be saved.

One of the laws that previously applied to the use of guns was the Armed Robbery and Firearms Decree of 1986. Today, that Decree has been replaced by the Robbery and Firearms (Special Provisions) Act, Cap R11, LFN 2004. The Act prohibits housing and sheltering of any person known to have committed an offence relating to robbery and firearms[240].

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238 . *Ibid, Section. 10*

239 . *Ibid, Section. 11*

240. *Robbery and Firearms (Special Provisions) Act 2004, Section. 4 (1)*

The Act further provides that it is the "duty of any person, hospital or clinic that admits, treats or administers any drug to any person suspected of having bullet wounds to immediately report the matter to the police[241]". The predecessor of the Act being the Armed Robbery and Firearms Decree of 1986 had similar position in *Section 4 (1) and (2).*

Credit must therefore be given to the minds that thought about the CTCVG Act. It is also a welcome development that penal provisions have been provided against defaulters. And the confusion highlighted above which before now had been a bane on the survival of gunshot victims has been clarified.

3.1.9 The Patients' Bill of Rights Act 2018

The Bill is simply an aggregation of rights that already exist in other instruments, such as **the 1999 Constitution, the African Charter, the Child Rights Act, the Consumer Protection Council Act, the Freedom of Information Act, the National Health Act**, etc.

It is axiomatic that the focus of the Bill is the guarantee of the right to health. A few words about this right will be appropriate. The World Health Organization (1946) defined the right to health as *"the enjoyment of the highest attainable standard of health, that should be available, physically and economically accessible, acceptable by medical ethics standard and of quality to all – regardless of race, religion, political belief, economic or social condition".*

The provisions of **Section *17(3)(d)* of the 1999 Constitution** (though – like other parts of **Chapter II of the Constitution** – are generally not justiciable) enjoin "*the State* (to) *direct its policy towards ensuring that there are adequate medical and health facilities for all persons*". These are complemented by ***Article XVI* of the African**

[241] . *Ibid, Section. 4 (2)*

Charter which provide that *"every individual shall have the right to enjoy the best attainable state of physical and mental health*", adding, for good measure, that *"State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick"* unlike *Chapter II* of the Constitution, the African Charter is enforceable in our courts: vide the **African Charter (Ratification and Enforcement Act, 1981).**

Additional enforcement mechanism (in relation to the Charter, and the Fundamental rights to life, dignity of the human person and liberty under ***Sections 33, 34 and 35*** **of the Constitution,** respectively, which impinge on health care rights) is provided under the **Fundamental Rights (Enforcement Procedure) Rules 2009.**

In ***Mustapha v Gov. Of Lagos State***[242], the Supreme Court declared that the fundamental rights provisions (of the Constitution) encompass all mankind and attach to a man because of his humanity. The capacity of the individual to enforce them has been settled in a myriad of cases.

Article XXVI of the Child Rights Act 2005 contains similar provisions, this time, in relation to children – which the Act defines as any person under the age of 18years. Additionally, ***Section 1(1)(c)*** **of the National Health Act, 2014,** enjoins (all) Governments in Nigeria *"to provide the best possible health services".*

The rights enshrined in the Nigerian Patients' Bill are as follows:

1. Access to Information

i. Right to relevant information in a language and manner the patient understands including the diagnosis, treatment, other procedures and possible outcomes (this right

[242]. *(1987) LPELR 1931*

is also provided for in *Article IX* of the African Charter which stipulates that "every individual shall have the right to receive information")

ii. To fully participate in implementing the treatment plan and making decisions.

iii. Right to timely access to detail and accurate medical records and available services (*Article IX* of the African Charter).

iv. Access to records of the identity, skills and credentials of treating professionals and care providers published by the Federal/State Ministry of Health or other relevant authorities.

v. Right to transparent billing and full disclosure of any costs, including recommended treatment plans (*Article IX* of the African Charter).

vi. Right to privacy and confidentiality of medical records unless disclosure is vital and in the interest of public health in accordance with prevailing laws (*Section 37 of the 1999 Constitution).*

vii. Access to clean, safe and secure healthcare environment.

viii. Access to equitable quality care and care-givers, irrespective of disability.

ix. Right to be treated with respect, regardless of gender, race, religion, ethnicity, allegations of crime, disability or economic circumstances (*Section 42 of the 1999 Constitution and Articles IV and V of the African Charter*)

x. That prior wishes of the patient or in the absence of same, of the *next-of-kin* (where legally applicable) are respected to the fullest extent practicable during last offices (at the time of death) including cultural or religious preferences, to the extent consistent with extant laws including Coroners laws.

xi. Right to receive urgent, immediate and sufficient intervention and care, in the event of an emergency, prioritizing such needed attention over other factors including cost and payment, as well as law enforcement requirements (*Article XVI* of the African Charter).

xii. Right to receive visitors including for religious purposes in accordance with prevailing rules and regulations (*Articles Xi and XII(i) of the African Charter and Sections 40 and 41 of the 1999 Constitution of The Federal Republic of Nigeria as amended)*.

xiii. Patients at all times, retain the control of their person and must be informed of their power to decline care, subject to prevailing laws and upon full disclosure of the consequences of such a decision (*Section 35 of the Constitution and Article VI of the African Charter*).

xiv. Patients have the right to consent or decline participation in medical research, experimental procedures or clinical trials in the course of treatment (*Section 35 of the 1999 Constitution of The Federal Republic of Nigeria as amended and Article VI of the African Charter*).

xv. To be informed about impending interruption or disengagement of services of primary or attending professionals responsible for patient's care.

xvi. Methodical and practical transition of treatment for patient's safety and continuity of care.

xvii. To express dissatisfaction regarding service and/or provider including personnel changes and abuse. **(***1999 Constitution of The Federal Republic of Nigeria as amended***).**

Apparently for the sake of balance, these rights are complemented in the Bill by a number of patients' responsibilities as well as those of healthcare providers which are, strictly speaking, outside the scope of this work. Suffice it to say that the assumption is that, as long as the patient "keeps his own part of the bargain" (observes his responsibilities) on the basis of *quid pro quo*, he (or she) would be fully entitled to complain about violations of his or her rights

under the Bill of Rights. So much for precepts; what about the reality, in terms of the mechanism(s), if any, provided for ensuring compliance with the Rights?

Enforcement of Patient Bill of Rights.

There are a number of structures and procedures in other laws not in the Patient Bill of Rights itself which can be beneficial (if not exactly salutary) in terms of seeking redress for violations of the Patient Bill of Rights. To start with, medical or health practitioners themselves are bound by a Code of Ethics which manifest in the legal principles dealing with medical negligence. This is defined (Black Law Dictionary) as the failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation. In the *locus classicus* of ***Bolam v Friern Hospital Management Committee***,[243] the court held that a doctor will not be liable for medical negligence if he acted in accordance with a practice regarded as proper by a responsible body of medical men, skilled in that particular art. In other words, he would only be liable if he acts otherwise.

However, a patient may challenge, through a civil suit, *sub-par* service provided by a health-care facility which constitutes medical negligence, for harm or injury incurred in the course of treatment. Apart from this common law right, the **National Health Act (in Part III)** also enjoins health-care establishments to provide grievance mechanisms through which patients may express complaints on the quality of services they received at the facility. The Act requires officials of State (such as Ministers, Commissioners of Health or Local Health Authorities) to provide procedures for laying complaints.

Additionally, a patient who is aggrieved by breach of any of the rights under the Patient Bill of Rights may challenge it through the mechanisms provided in the FCCPC Act – apart from

[243] . *[1957] 1 WLR 583*

instituting disciplinary proceedings against a medical practitioner/healthcare provider under the Medical and Dental Practitioners Act**.** The former provides a general legal mechanism for protecting consumer rights in Nigeria. It was this mandate that informed the FCCPC (formerly CPC) – in conjunction with other healthcare stakeholders – to introduce the PBoR. Under the Act, a patient who perceives that he or she has suffered loss, injury or damage may complain in writing to seek redress through the FCCPC (complaints are typically resolved between 1 and 45 days). There is provision for a tribunal to review the Commission's decision. Of course, this right is *co-terminus* with the consumer (patient's) right to seek redress through civil action for compensation or restitution.

Servicom (or Service Compact with Nigerians) is yet another mechanism for protecting patient's health-care rights. *Servicom* is a means of promoting effective and efficient service delivery in Government (Federal) Ministries, Departments & Agencies (MDAs) for the purpose of ensuring customer (or patient) satisfaction and to manage the performance-expectation gap between the Government and citizens/other members of the public on issues of service delivery. Launched in 2004, it is conceptualized to fight service failure by ensuring that government organs deliver to the public, the services to which they are entitled. Operating through a network of ministerial units established in all MDAs, Servicom's impact in the health-care delivery system has been restricted to Government (usually Federal-owned) University Teaching Hospitals.

3.1.10 CONSUMER PROTECTION ACT, 1986

Consumer Protection Act, 1986 was enacted by the parliament to provide for better

protection of the interest of the consumers in the background of the guidelines, contained in the Consumer Protection Resolution passed by the United Nations General Assembly on 9th April, 1985. The legitimate needs which the guidelines intend to meet include – protection of consumers from hazards to their health and safety and availability of effective consumer redress.

Accordingly, the Consumer Protection Act, 1986, is to provide protection and relief to persons who have hired any services for consideration when the services provided are found to be suffering from deficiency in any respect[244] According to the Apex Court, a determination about deficiency in medical service is to be made by applying the same test as is applied in an action for damages for medical negligence[245]

Since the very purpose for which the statute was enacted is to provide a cheap and speedy remedy to the aggrieved customers by way of an alternative to the time consuming and expensive process of civil litigation, the consumer forum cannot refuse to adjudicate the dispute regarding deficiency in service rendered by medical practitioners for consideration[246]

The Consumer Protection Act, 1986 is another legislation that has influence on the medical profession with regard to monitoring the activities of the surgeons/other medical practitioners.

The Nigerian Consumer Protection Act 1992 established the Consumer Protection Council and the various committees with the mandate of carrying out the functions under *Section 2* of the Act. Some of the functions include, but not limited to, the following:

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[244]. Consumer Unity and Trust Society, *Janipar v. State of Rajasthan 1991 (I) CPR, 241 (NC) 1 (1992) CPJ 259 (NC) (1993)1 CTT 89 (NCDRC).*

[245]. *Indian Medical Association vs. V.P Shantha AIR* 1996 SC 550; (1995) 6SCC 651; 111 (1995) CPJI (SC), 1995(3) CPR 412 (SC), (1995) 3 CTJ 969 (SC) (CP); 1996 CCJI (SC).

[246] . *S.K. Abdul Sukur vs. State of Orissa II (1991) CPJ 202 (NC).*

a) The council is to provide speedy redress to consumers complaints through negotiation, mediation and conciliation;

b) The council is to seek ways and means of removing from the markets hazardous products and causing offenders to replace such products with safer and more appropriate alternatives.

In the exercise of the above provisions, the council has power, amongst others to;

i. Apply to the court to prevent the circulation of any product which constitutes public danger or imminent public hazard;

ii. Compel manufacturers to certify that all safety standards are met by their products; and

iii. Cause, as it deems necessary, quality tests to be conducted on consumer products."

Section 9 (1) of the Act states that a manufacturer or a distributor of a product, on becoming aware of any unforeseen hazard, is under a duty to notify the public and withdraw the product

from the market with immediate effect.

The issue here is whether the Consumer Protection Act in Nigeria covers the medical service?

Section 2(1) of the CPA provides that the word Service means service of any description that is made available to any potential users and includes but not limited to, the provision of facilities, in connection with banking, financing insurance, transport processing, supply of energy or electrical, housing construction, entertainments and so on.

It may be appropriate here to mention that whereas CPA has been made applicable to all goods

and services, two types of services have categorically been kept out of the purview of this Act.

These are services rendered free of charge and service rendered under a contract of personal service. The contract of personal service has been debated a lot of times before the consumer specialists for and in a number of cases. For example, President, National Consumer Disputes Redressed Commission (NCDRC), delivered a land mark judgment in *Cosmopolitan Hospital and Anor vs. Vasantha*[247]**.** In this case, held that the activity of providing medical assistance for payment carried on by the hospital and members of the medical profession, falls within the scope of the expression service as defined in *Section. (1)* of CPA. Thus, in the event of any deficiency in the performance of such service, the aggrieved party could invoke the remedies provided under the Act by filing a complaint before the Consumer Forum having jurisdiction. It has also been held that legal heirs of the patient/s who were undergoing treatment in the hospitals are consumers under the Act and were competent to make their own complaints.

3.1.11 National Agency for Food and Drug Administration and Control Act, Cap N.1 LFN 2004

NAFDAC came into being to stop the spread of adulterated and counterfeit drugs, foods and medical devices that militates against the well-being of the people. The agency by virtue of its mandate is charged to amongst other things regulate and control the manufacture, importation, exportation, advertisement, distribution and sale of foods drugs cosmetics, medical devices, bottled water and chemicals in Nigeria[248]. NAFDAC oversees all aspects of drug medical devices in addition to other regulated products[249].

Its functions are stated in *Section 5* of the Decree. *Section 1* of Act established the Governing

[247] . *(1991) (2) CPR 155 (Ker) 11 (1991) CPJ 144*

[248]. *Section 5 of the NAFDAC Act*

[249]. *Section 30* of the NAFDAC Act defined „regulated products to include (food drugs cosmetics medical devices and bottled water)

Council which consists of experienced professional from health care system in the country. For it to function effectively and efficiently, the agency is divided into different directorates as follows:

a) Administration and Human Resources Directorate;

b) Planning, Research and Statistics Directorate (PR&S);

c) Narcotics and Controlled Substances Directorate;

d) Registration and Regulatory Affairs Directorate (R&R);

e) Port Inspectorate Directorate and

f) Establishment Inspectorate Directorate (EID);

g) Laboratory service Directorate;

h) Enforcement Directorate;

i) Finance and Account Directorate.

From its initial inception, NAFDAC had recorded considerable success in fighting against fake and counterfeit drugs. A survey across the country showed that 70% of drugs circulating in Nigeria as of 2001 were counterfeit[250]. Nigeria had experienced several tragedies as a result of fake and counterfeit drugs. However, in 2006 NAFDAC published a survey showing a 90% decrease in the incidence of counterfeit drugs in circulation and a take of US dollar 100 million in counterfeit drugs seized and destroyed over a period of 5 years.

However, despite the recorded success of NAFDAC, fake and counterfeit drugs are still widely available and sold openly in the markets, patents and proprietary medicine vendors. License vendors continue to sell drugs outside the scope of their license with reckless abandon and on radio and T.V; there are advertisement for the treatment of all kinds of

250 . E.I Alamika, *Legal Framework for Food and Drug Security in Nigeria*, <http:/ dspace.unijos.edu.ng>law>public law> a ccessed 01/07/2022.

disease by traditional medicine practitioners in stark disregard for the laws governing the advertisement of certain disease[251].

3.2 Institutional Framework

This segment of the thesis will discuss the institutional frameworks on the practice of medicine in Nigeria.

3.2.1 Medical and Dental Council of Nigeria:

The primary medical regulatory body in Nigeria is the Medical and Dental Council of Nigeria (MDCN). It is a statutory regulatory body set up by law. Its stated purpose is to regulate the practice of Medicine, Dentistry and Alternative Medicine in the most efficient manner that safeguards best healthcare delivery for Nigerians. The Act (Medical and Dental Practitioners Act Cap 221 [now Cap M8] Laws of Federation of Nigeria 2004 sets up the MDCN and charges the council with the following responsibilities:

1. Determining the standards of knowledge and skill to be attained by persons seeking to become members of the medical or dental profession and reviewing those standards from time to time as circumstances may permit;
2. Securing in accordance with provisions of this Law the establishment and maintenance of registers of persons entitled to practice as members of the medical or dental profession and the publication from time to time of lists of those persons;
3. Reviewing and preparing from time to time a statement as to the code of conduct which the Council considers desirable for the practice of the professions in Nigeria;
4. Performing the other functions conferred on the Council by this Law;

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[251]. *Section 2(a) of Food and Drugs Act* which prohibited the advertisement of certain drugs listed in the FirstSchedule to the Act.

5. Supervising and controlling the practice of *homeopathy*, and other focus of alternative medicine (*naturopathy, acupuncture and osteopathy*); and

6. Making regulations for the operation of clinical laboratory practice in the field of pathology, which includes *histopathology*, forensic *pathology*, *autopsy a*nd *cytology*, *clinical cytogenetics, haematology, medical microbiology* and *medical parasitology, chemical pathology, clinical chemistry, immunology and medical virology*.

Since its inception in 1963, the MDCN has published certain documents as guidelines for registered practitioners and those who want to become members of either profession. These documents include:

a. The Red Book: Guidelines on the Minimum Standards of Medical and Dental Education in Nigeria; and

b. Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria.

The Council is empowered to make rules of professional conduct and to establish the Medical and Dental Practitioners Disciplinary Tribunal and Medical Practitioners Investigating Panel for the enforcement of these Rules of Conduct. The MDCN is, therefore, responsible for setting, maintaining and ensuring the standards for doctors' education (in particular, basic training), registration, licensure, and disciplinary issues. *Sections 9 and 10* of the Act empowers the Council to approve the courses, qualifications, and institutions intended for persons who are seeking to become members of the medical and dental profession, the supervision of instructions and examinations leading to approved qualifications.

The implication of the above is not to impose curriculum on the medical schools. Rather, it is meant to follow the broad guidelines laid down by the council in specific areas such as the

subject matter, which the curriculum may cover, and the minimum length of time which the students must spend in the undergraduate training programmes. It is of note that registration is the prima facie evidence that a person has registered as a medical or dental practitioner as the case may be. A person, whose name has been fraudulently entered, does not by such registration become a medical practitioner or a dental surgeon. If the fact of the fraud is discovered, definitely, the name of the fraudster would be struck out of the register by the council.

3.2.2 Medical and Dental Practitioners Disciplinary Tribunal

The Medical and Dental Practitioner's Act (MDPA), 2004[252] established the Disciplinary Tribunal with the duty of considering and determining any case referred to it by the Panel. The membership of the Disciplinary Tribunal is made up of the chairman of the Council and ten others. The disciplinary power of the Tribunal over medical practitioners and dental surgeons is undoubtedly very important and viable power of the Council. It is a very important function because of the high premium placed on the maintenance and promotion of professional discipline and etiquette of the profession.

The disciplinary measures are exercisable over erring registered medical practitioners and dental surgeons. *Section 16* of the Act provides for three broad instances in which the Council, through the Tribunal, will invoke its disciplinary powers.

These are:

1. Whether a registered person is adjudged by the disciplinary tribunal to be guilty of infamous

conduct in any professional respect; or

2. Whether a registered person is convicted by any court of law or tribunal in Nigeria or

[252] . *Section 15 Medical and Dental Practitioner's Act (MDPA), 2004*

elsewhere having power to impose punishment, for an offence, (whether or not an offence is punishable with imprisonment) which in the opinion of the disciplinary tribunal is incompatible with the status of medical practitioner or a dental surgeon, as the case may be.

3. Whether the disciplinary tribunal is satisfied that the name of any person has been fraudulently registered.

The Orders which Disciplinary Tribunal can make are stipulated in *Section 16 (2)* as follows:

i. It can order the Registrar to strike out the name of the erring practitioner from the register;
ii. It can suspend the person from practice for a period not exceeding 6 months; and
iii. It can admonish the person.

A person whose name is removed from a Register in pursuance of direction of the Disciplinary Tribunal under this section shall not be entitled to be registered in that Register again except in pursuance of a direction in that behalf given by the Disciplinary Tribunal on the application of that person. There were number of cases where the tribunal has found some medical practitioners guilty of infamous conduct. For instance, In the case of *Olaye vs. Chairman, Medical & Dental Practitioners Disciplinary Tribunal (MDPDT)*[253], in this case, the appellants and three other medical practitioners were charged before the Disciplinary Tribunal for negligence by their non-attendance to a patient contrary to the ethics of the medical profession. Though the appellant denied liability, the tribunal found him liable and directed that his name be struck off the Register of Medical and Dental Practitioners in Nigeria. The Nigerian Court of Appeal allowed the appellant's appeal on mere technical ground of non-observance of rules of natural justice by the tribunal.

[253] . *(1977) NMLR pt 506 P. 550*

In the Nigeria case of *Denloye vs. Medical & Dental Practitioners Disciplinary Tribunal (MDPDT)*[254], Denloye was charged with neglecting in a prolonged manner between 29th June 1966 and the 10th July 1966 a patient very seriously ill, extorting the sum of 30 guineas from the patient's father as an inducement for him to treat the patient among other allegations. The Tribunal pronounced him guilty of infamous conduct in a professional respect and ordered the removal of his name from the Medical Register. On final appeal to the Supreme Court of Nigeria, it set aside the decision of Tribunal also on technical ground of non-observance of rules of natural justice.

In *Akintade v Chairman, Medical & Dental Practitioners Disciplinary Tribunal* (MDPDT)[255], Court of Appeal held that the term infamous conduct include, failure to attend to patient promptly, incompetence in the assessment of the patient, deficient treatment arising from inadequate pre-operative investigation, deficient operative procedure and poor and faulty post-operative management.

In *Alakija v Medical Disciplinary Committee*[256], the committee ordered the removal of Alakija's name from the Register of Medical Practitioners for two years. The Supreme Court of Nigeria later quashed the decision on technical grounds of non-observance of rules of natural justice.

In the case of *Okezie v Chairman Medical & Dental Practitioners Disciplinary Tribunal (MDPDT)*[257], Dr. Okezie, a Registered Specialist Obstetrician and Gynecologist and a Lecturer at University of Nigeria Teaching Hospital, Enugu was found guilty of infamous

[254]. *(1968) 1 All NLR 306.*
[255]. *(2005) 9 NWLR (pt. 930) 338 p.5*
[256]. *(1959) FSC 38*
[257]. *(2010) 26 WRN*

conduct and gross professional negligence in 2001. He was suspended from practices for six months for losing his patient (Mrs. Obiekwu) after a caesarian operation. The charges against him include negligent failure to secure the professional services of an anesthetist and also of qualified registered nurses to provide necessary professional care as required before, during and after the caesarian operation; failure to provide cross-matched bloods and oxygen which would have been used to resuscitate the patient at the time of impending respiratory failure which eventually set in post operatively; operating at an unregistered institution known as Christian Miracle Hospital. About 10 years later, the Court of Appeal set aside the Disciplinary Tribunal's decision of the Disciplinary Tribunal for non-observance of the law of natural justice.

What could be deduced from the foregoing Nigerian case laws is that while the professional tribunal in Nigeria has been very justifiably strict on reported cases, reported for ethical breaches of members, the Nigerian courts have been more liberal than the Tribunal in the approach to ethical breaches, as they heavily rely on technicalities and not substance to exonerate felonies.

3.2.3 Nigerian Medical Association

The NMA has been a long time association of all medical doctors and dentists. It shares the same objectives as the MDCN, as stated in the Codes of Ethics and Conduct. It commands the allegiance of all doctors and dentists in the land. It is the largest medical association in the West African sub-region. It has over 35,000 members from 36 state branches and the

branch from the Federal Capital Territory. About 70% of the doctors associated with the NMA practice in urban areas where only 30% of the Nigerian population resides[258].

The governing body of the NMA is the NOC and National Executive Council. It has powers to act on its behalf in the period between the Annual Delegates' Meetings in accordance with the Constitutional provisions of the Association. Referring to Act of the Medical and Dental Practitioners, any registered medical and dental practitioner has the right to become a member of the Association on payment of the annual fee. There are six main categories of members ordinary members, life members, honorary members, associate members, student members and distant members. However, it is only formally consulted by the government on an *ad-hoc* basis and it has to press for its participation. At present, the NMA is not only involved in influencing health policy formulation in an *ad-hoc* manner. It plans to be more explicitly involved in all aspects of policy formulation, especially in the planning stages, and is currently and actively involved in talks with the federal Ministry of Health to make this happen.

The NMA is not a statutory organization but has a constitutional recognition pursuant to the right to form association. However, in making reference to the Medical and Dental Practitioners Act, this Act in *Section 14* shows that the Act recognizes the existence of the association. It has the power under the Act to report and file complaints before the Tribunal.

3.2.4 The Pharmacists Council of Nigeria

[258]. International Comparison of Ten Medical Regulatory Systems retrieved from <http://www.gmc-uk.org/International > Comparison of Ten Medical Regulatory Systems final report. Accessed on the 21/07/2022

The Pharmacists Council of Nigeria (PCN) is a public corporation created by the Federal Government of Nigeria in 1992 with the sole responsibility to register, monitor, regulate and control all aspects of pharmacy practice in Nigeria, including the education and training of pharmacists and pharmacy-related personnel (PCN, 2015). The PCN was established to create an enabling and adequately regulated environment for the provision of quality Pharmaceutical Services for sustainable health care delivery (PCN, 2015). The council formulates the corporation's policies and takes related decisions which may be classified into (PCN, 2015):

a. Registration and control initiatives

b. Monitoring and regulatory functions

c. Education and training program and

d. Appropriate information and publications in support of functions

In accordance with the mandate of the PCN to standardize and control all aspects of education and training for pharmacy and related occupations in Nigeria, setting appropriate standards as benchmarks in the practice of pharmacy in different areas of specialization is a major statutory responsibility of the PCN The compendium has, for the first time in the history of pharmacy regulation in Nigeria, set the benchmarks of the minimum levels of practice required for the assurance of pharmaceutical care in hospital pharmacy, Retail/Community pharmacy, pharmaceutical manufacturing and the wholesaling/importation of pharmaceutical products.

The State and Zonal offices are headed by competent pharmacists with appropriate qualification and experience who are directly involved in pharmaceutical inspection activities among others while the Directors of Pharmaceutical Services in the State Ministry of Health

(DPS, MOH) are delegated as the chairpersons of both the Pharmaceutical Inspection Committee (PIC) and Patent and Proprietary Medicine Vendors Licence (PPMVL), the two committees of Council involved in inspectorate activities for pharmacies and patent medicine stores. Due to inadequacy of Inspectors to carry out the inspectorate activities, pharmacists who are not staff of PCN that are of good standing were also appointed by PCN to work in collaboration with PCN in these activities under a Public Private Partnership (PPP) arrangement.

The pharmacists Council of Nigeria, in summary are responsible for:

i. Determining the standard of knowledge and skill to be attained by persons seeking to become registered members of the Pharmacy Profession(in this Act referred to as the profession) and reviewing those standards, from time to time as circumstances may require

ii. Securing in accordance with the provisions of this Acts, the establishment and maintenance of register of person entailed to practice as members of the profession and the publication, from time to time of lists of those persons

iii. Reviewing and preparing from time to time, a statement as to the code of conduct which the council considers desirable for the practice of the pharmacy profession.

iv. Regulating and controlling the practice of the profession in all its aspects and ramifications.

3.2.5 The Nursing and Midwifery Council of Nigeria

The Nursing and Midwifery Council of Nigeria (NMCN) known as "The Council" is the only professional Council for all grades and Cadres of Nurses and Midwives in Nigeria.

The Council is the only legal and administrative, corporate and statutory body charged with specific functions to perform on behalf of the Federal Government of Nigeria to ensure the delivery of safe and effective Nursing and Midwifery care to the public through quality education and best practices.

The Nursing and Midwifery Council of Nigeria is a category B parastatal of the Federal Ministry of Health established by Decree No. 89, 1979 now known as Nursing and Midwifery (Registration etc) Act. Cap. N143, Laws of the Federation of Nigeria, 2004. The Council is a body Corporate with perpetual succession and a common seal.

The Council is mandated by Law to regulate the standards of Nursing and Midwifery Education and Practice in Nigeria and to review such standards from time to time to meet the changing health needs of the society.

The primary objectives of the Nursing and Midwifery Council of Nigeria are to ensure high quality of Nursing and Midwifery education in Nigeria, maintain high standard of professional nursing and midwifery practice and enforce discipline within the profession.

The Council has its headquarters in Abuja with Zonal Offices in Sokoto, Kaduna, Bauchi, Enugu, Port Harcourt and Lagos.

The Council is headed by a Secretary General/Registrar and is assisted by other professionals and non-professional staff. They are responsible to a Board headed by a Chairman with members drawn from various institutions and zones in the country.

The primary objectives of the Nursing and Midwifery Council of Nigeria are to ensure high quality of Nursing and Midwifery education in Nigeria, maintain high standard of professional nursing and midwifery practice and enforce discipline within the profession.

Broadly, the Council's functions are related to those of designing, implementing and evaluating various nursing and midwifery educational programmes, of *indexing*, examination, registration, certification, licensure of professional nurses and midwives and monitoring standards of nursing and midwifery practice in the Country.

Specifically, the Council's functions are as follows:

1. *Index* all categories of nursing and midwifery students on commencement of their training.
2. Develop and review periodically, the different curricula utilized for the education of all categories of Nurses and Midwives.
3. Co-operate with recognized bodies interested in conducting new schemes for Basic and Post Basic Education of Nurses and Midwives such as: National Universities Commission, World Health Organization, etc.
4. Accredit all training institutions and clinical practice areas utilized for the education of all categories of Nurses and Midwives in Nigeria.
5. Conduct Professional Examinations for all categories of Nurses and Midwives in Nigeria.
6. Establish and maintain Registers of all persons qualified to practice the discipline of Nursing and Midwifery in Nigeria.
7. Conduct Registration interviews for Nurses and Midwives trained outside Nigeria who are seeking to practice in Nigeria.

8. Issue and update Professional Practicing Licenses every three years to all cadres of qualified Nurses and Midwives.

9. Issue Professional Certificates to all cadres of Nurses and Midwives at the end of their training.

10. Revoke and/or Restore Professional Certificates as applicable.

11. Determine and maintain standards of knowledge and competencies in Nursing and Midwifery Education and Practice in Nigeria.

12. Organize and Conduct Mandatory Continuing Professional and Educational Development Programmes for all cadres of Nurses and Midwives.

13. Conduct and Promote Research in relevant areas of Nursing and Midwifery.

14. Maintain discipline within the Nursing and Midwifery profession in Nigeria through the Nurses and Midwives Tribunal.

15. Prosecute illegal Training Institutions.

16. Regulate and control the practice of Nursing and Midwifery in all its ramifications.

3.2.6 The Federal Ministry of Health

The Federal Ministry of Health is the apex federal government institution vested with the responsibility to develop and implement health policies and programs and also undertake the action to deliver effective efficient quality and affordable health services in Nigeria.

The FMOH has five departments and is the main layer for policy making, strategic planning, regulating international relations and central source for technical support and guidance for states. The FMOH is linked to thirty six states and the Federal Capital Territory (FCT) and the 774 local government of Nigeria by providing them with technical support and

guidance.

The federal ministry of health in Nigeria saddled with a number of functions targeted towards actualizing the mandate of the federal ministry.

1. **Formulates And Legislates Health Policy And Plan**: One function of the federal ministry of health is to ensure that, health policy and health plan are formulated. The federal ministry of health is expected also to make sure that these policies and plans are legislated in the most appropriate way in order to achieve the goals and objects of the federal ministry.

2. The Federal Ministry of Health Regulates Functions Another function of the federal ministry of health is to regulate functions. Its function at this level is not limited to function regulations, it goes beyond that, it include, quality assurance, such as setting of standards for the ministry personnel, and health facilities and health infrastructure Services for the registration of public and registration of private health agencies operating within Nigeria also included, plus evaluation of functions and monitoring of activities.

3. **Federal Ministry of Health Develops And Implements Strategies For Health Sector**

The above is one of the functions of the federal ministry of health. The federal ministry health is saddled with the responsibility of developing and implementing strategies related to the health sector. The function of the federal ministry of health has however, gone beyond development and implementation of health strategies.

It function also include the promotion of PPP, that is, Public Private Partnership in health sector with a view to boost health care delivery in the country.

4. **The Federal Ministry Of Health Supervises And Controls Health Facilities**

The supervision and the control of every health care facilities is the function of the federal ministry of health. The purpose of this supervision and the control of health facilities is simply to make sure that a minimum standard in private and public health care facilities is maintained. This is one of the major functions of the federal ministry of health.

5. **Supervises Hospital Governing Boards, Government Health Agencies, Etc.**

Another function of the federal ministry of health is to supervise, as well as control everyone of the Hospital Governing Board, every government Organization and ever government Agency. The reason here is very important, since these government organizations and agencies must have to work in line with the laid down rules and regulations, related to quality health care delivery.

6. **The Federal Ministry Of Health Approves Health Regulations**

The approval of all the regulations related to health care, including that of the subsidiary legislation is actually, one of the functions of the federal ministry of health. Until such regulations and legislation is approved by the federal ministry of health, such regulations cannot be bound on the health care personnel.

3.2.7 The Judiciary

The Constitution[259] established courts under Chapter VII and made them custodian of fundamental rights[260]. Being protectors of fundamental rights, the court has a constitutional responsibility under Section 13 to see to the observance of the fundamental objectives in the

[259]. N.A Ijeoma,. (2012).Gender and Reproductive Health: Towards Advancing Judicial Reforms in Nigerian <www.panafrican-med-journal.com/content/article/16/10/full/> Accessed 07/07/22

[260]. 1999 Constitution of the FRN as amended 2011

constitution[261] and also the rights contained in the African Charter on Human and People's Rights.

Being protectors of fundamental rights, the court has a constitutional responsibility under S 13 to see to the observance of the fundamental objectives in the constitution[262] and also the rights contained in the African Charter on Human and People's Rights[263].

There is a steadily growing medical cases in the legal environment in Nigeria, with a total of 190 judgments of professional negligence against doctors between year 2000 and 2007 and this represents a two hundred percent increase from the previous records of only 92 petitions from 1963- 1999[264]. It is imperative to consider some of the cases briefly:

Tanko V. Okekearu[265] Danjuma Tanko is a 14 years old boy. He damaged his centre finger. Dr. Okekearu while treating him amputated his finger. Tanko sued through his next friend that he did not consent to the amputation. Dr. Okekearu claimed to have sought and obtained the consent of Tanko's aunt. The court held that the consent of the aunt was invalid and damages was awarded.

The case of Navy Capt/Dr. Olowu[266]: who failed to personally examine the patient having complications in pregnancy for 15 hours. He merely wrote a letter of referral when the situation had already become bad as she was already bleeding profusely from the vagina. She was later operated upon in another facility where it was discovered that the baby died about 24 hours with several complications and inability to further conceive. The Federal High

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261. See *Section 46(1) Ibid*
262. Apart from the Judiciary, other organs of the government i.e. the legislative and the executive have the responsibility under *Section 13* to pursue health objectives
263. *Gani v Abacha (2006*) See *Section 16 of the African Charter.*
264. Olaolu A. Osanyin, *Development of Health Law in Nigeria (The Open Season of Malpractice Suits (4/24/2015)*
LCM https://aclm.memberolicks.net>Accessed 01/08/2022.
265. *Surgeon Captain C. T. Olowu v. The Nigerian Navy* (Friday, 9th day of December, 2011)
266. *(2005) 9 NWLR Pt. 930, 338, 5.*

Court, Lagos, awarded N100 million damages against the Nigerian Navy and Captain C.T Olowu, for negligence. The Court Martial consequently demoted him from the rank of captain to commander, a four-year reduction in seniority.

The Nigerian courts have shown the willingness to prosecute cases arising from medical negligence which can be a tortuous act. The judiciary do not shy away to make sure that Doctors, who are careless, negligent and carefree about their jobs and against their medical ethics are hit with the judicial rods.

The Judiciary is not shy in making pronouncements, although some cases have been dismissed on the grounds of lack of fair hearing.

CHAPTER FOUR
TORTUOUS LIABILITY OF MEDICAL PRACTITIONERS IN NIGERIA.

4.1 The Nature of Negligence of Medical Practitioners

Medical negligence is a legal cause of action that occurs when a medical or health care professional, through a negligent act or omission, deviates from standards in their profession, thereby causing injury to a patient. The negligence might arise from errors in diagnosis, treatment, aftercare, or health management.[267]

An act of medical malpractice usually has three characteristics. Firstly, it must be proven that the treatment has not been consistent with the standard of care, which is the standard medical treatment accepted and recognized by the profession. Secondly, it must be proven that the patient has suffered some kind of injury due to negligence. In other words, an injury without negligence or an act of negligence without causing any injury cannot be considered malpractice. Thirdly, it must be proven that the injury resulted in significant damages such as disability, unusual pain, suffering, hardship, loss of income, or a significant burden of medical bills.[268]

According to Alderson B., in *Blyth v. Birmingham Water Works Company Co.*[269], Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would do, or doing something which a prudent and reasonable man would not do. Simply put therefore, "negligence is the breach of a legal duty to take care which results in

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267 F. A. Fagbemi*, Medical Negligence in Nigeria*, 2017, Xerxes Publishers, Abuja, p. 43

268 *Ibid*

269 . (1856) 11 EX. 781,784

damage, undesired by the defendant to the plaintiff[270]."Negligence in medical practice ordinarily implies that the medical practitioner had the consent of his patient to treat him, but such treatment did not conform to the standards imposed on the medical practitioner by law. An action in negligence involves three basic elements:

1. The nature of the duty that the law imposes on the medical practitioner;
2. The alleged conduct that constitutes the breach of that duty in the eyes of the law and;
3. The causal relationship between the breach of duty and the injuries of which the victim complains.

The courts generally regard the relationship between patients and medical practitioners as contractual.[271] When a patient presents himself to a medical practitioner for medical care, and the medical practitioner proceeds to render that care, the law implies that a contract has arisen between the parties. It is from this contractual relationship that the duty of the medical practitioner to his patient arises. In medical professional liability litigation, the trend has been for the patient to bring suit against the physician for alleged failure to use reasonable care and that action is usually in tort. According to Halsbury's Law of England[272],

> A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, whether he is a registered practitioner or not who does a patient, consult, owes him certain duties, namely, a duty of care in deciding what

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[270] . W.V.H. Rogers, *Winfield & Jolowicz on Torts*, Sweet and Maxwell London, 1975 P.5.

[271] . R. Crawford Morris and Alan R. Moritz, *Doctor and patient and the Law*, Fifth Edition C.V. Mosby Co., Saint Louis, 1971. P. 326.

[272] . 3rd Edition (Simond's Edition) Vol. 26, article 22 at P. 17, quoted by sale Mohammed in the Tort of Negligence Under Nigerian Law, Unpublished LL.M. Thesis 2016, Faculty of Law, Ahmadu Bello University Zaria Nigeria, P. 146.

> treatment to give and a duty of care in the administration of that treatment. The practitioner must bring to his task a reasonable degree of care. Neither the very highest, nor very low degree of care and competence judged, in the light of the particular circumstances of each case is what the law requires; a person is not, liable in negligence because someone else of greater skill and knowledge would have prescribed different way; not is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art, although a body of adverse opinion also existed among medical men.

Consequently, if a medical practitioner holds out himself as a good surgeon, he must measure up to the standard generally approved or acceptable in the field of surgery (not a specialist in a particular area of medicine), then he is accordingly expected to measure up to the generally acceptable standard for general practitioners[273].

Therefore, the standard is not constant; it is dynamic and changes in accordance with the area of specialization of each doctor. Differences in circumstances and facilities at the place of work may also affect the standard required in each case. Thus, more efficient medical services may be expected in a modern well-equipped hospital than a village medical center.[274]

This liability is meant to serve two main purposes. Firstly, it provides compensation to those injured as a result of negligence, thereby acting as a source of insurance. Secondly, it serves as a deterrence that will prevent future occurrence of the negligence. The tortious liability is usually a civil action brought by the patient or his heirs. Tortious liability can either be primary or vicarious

A vicarious liability should not be confused with primary liability of hospitals. Apart from vicarious liability, a hospital may commit a breach of duty of care, which it owes to another, that

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[273]. Umerah B.C, *Medical Practice and The Law in Nigeria*, Longman, Nigeria, 2009, P. 124.

[274] . *Ibid*

is, a hospital may be in breach of its own duty to another. An example of this is where a hospital is at fault for selecting an unskilled person as its staff who conducts himself in a wrongful manner, or allowing such a person to continue in employment; or where it provides defective equipment for use by the health care team under its employment[275].

When we refer to vicarious liability, it is a liability where a master incurs damages to the third party because of a wrong committed by his servant in his employment. This does not matter whether the master didn't commit the offence himself. But for a liability of a master to occur, there must be a relationship of master/servant which is distinct from employer and independent contractor. The management of the hospital is always vicariously liable for the offence its staff commits. This is because the healthcare team is the servant of the hospital who employed them. Examples of these are Surgeons, Radiographers, Pharmacists, Nurses, full time Assistant Medical Officers, Anesthetists and so on. These are servants of the hospital authority being referred to as being vicariously liable. Vicarious liability of the master arises on the primary liability of the servant. The servant is the principal *tort feasor* while the master is the accessory. Thus, a plaintiff could sue both the health care provider and the hospital jointly. He may also sue either of them. The usual thing is to join the employer as a defendant. At times, the plaintiff may not be able to specifically identify which of the several servants of the master was negligent.

4.1.1 Diagnosis

A misdiagnosis or delayed diagnosis itself is not evidence of negligence. Skillful doctors can and do make diagnostic errors even when using reasonable care.

The common law does not hold doctors legally responsible for all diagnostic errors. Instead, patients usually must prove three things in order to prevail in a medical malpractice lawsuit based on a wrong diagnosis:

[275] I. P. Enemo, *The Law of Tort* (Enugu: Chenglo Ltd, 2007) p. 306

i. A doctor-patient relationship existed.

ii. The doctor was negligent -- that is, did not provide treatment in a reasonably skillful and competent manner.

iii. The doctor's negligence caused actual injury to the patient[276].

First case, which relates to improper diagnosis, is the case of *Pundey v. Union – Castle Mail S.S. Co. Ltd & Anor*[277]. In that case, the plaintiff, a member of crew of the first defendants' steamship called *Llaustephan* Castle fell sick, complaining of rheumatism while they were on voyage from London to the east coast of Africa,via Cape Town. He was then examined by the ship's doctor, the second defendant, who prescribed treatment for him and also recommended that he be repatriated. The plaintiff's health further deteriorated. He was again examined by a specialist who discovered that the plaintiff was suffering from acute arthritis. The plaintiff then brought an action against the first and second defendants claiming damages on the grounds that the second defendant was negligent in his diagnosis and treatment. Evidence of a similar symptom of rheumatism by other doctors who examined him before his repatriation was however adduced.

The court held that the plaintiff, had not only failed to prove that the second defendant was guilty of any lack of care in his diagnosis or treatment but that, taking into account the symptoms then observed by him and his fellow doctors, the medical evidence confirmed that he had in fact prescribed the correct treatment.

Even though the decision of the case as in favor of the defendants, it still demonstrates the

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276 Kathleen Michon, *"Medical Malpractice: Misdiagnosis and Delayed Diagnosis* https://www.nolo.com/legal-encyclopedia/medical-malpractice-misdiagnosis-delayed-diagnosis 32288.html#:~:text=A%20misdiagnosis%20or%20delayed%20diagnosis,in%20arriving%20at%20a%20diagnosis. Accessed 30th January, 2023

277 (1953) 1 Lloyds Rep. 73.

principle that where a doctor is found to be negligent, he can be made to pay damages to the plaintiff for any injury he may have suffered as such. The medical practitioner in the above case escaped liability because there were evidences from other doctors who had examined the plaintiff before, showing similar symptoms of rheumatism; otherwise, he would have been found liable.

To prove medical malpractice case based on diagnostic error, the patient must prove that a doctor in a similar specialty, under similar circumstances, would not have *misdiagnosed* the patient's illness or condition. In a practical sense, this means proving one of two things:

a) The doctor did not include the correct diagnosis on the differential diagnosis list, and a reasonably skillful and competent doctor under similar circumstances would have.
b) The doctor included the correct diagnosis on the differential diagnosis list, but failed to perform appropriate tests or seek opinions from specialists in order to investigate the viability of the diagnosis[278].

Where the facts and circumstances of a case show that there was an unequivocal instance of poor diagnosis, the courts are always ready to yield to the deserving cases.

Thus, In *Fortner v. Koch*[279], the plaintiff came to the defendant physician with a swelling on his knee and additional symptoms that might leada physician to suspect a variety of conditions. The physician examined the patient manually, placed him on a diet, and injected a solution into his bloodstream. Severe injuries followed. It was shown at the trial that the usual practice among

278 *ibid*
279 272 Mich. 273, 261 N.W. 762 (1935).

physicians in the community under these circumstances was not only to take the history of the patient but also to make an x-ray study, a blood test an a *biopsy*. These were not considered alternate tests. All of them were required. The defendant was held guilty of negligence for failing to make these diagnostic tests

Sometimes a Doctor fails to correctly diagnosis a condition because they relied on inaccurate results from laboratory tests, radiology films, or other types of tests. This can happen in one of two ways:

i. The diagnostic equipment was faulty.
ii. Human error occurred -- for example, the samples were contaminated or mixed up, the technician used an improper procedure, the test results were read incorrectly, or the technician or specialist missed something in an x-ray or pathology slide.

Although the doctor might not be liable for medical malpractice in this situation, another person might be such as the technician that misread the *pathology* slide. Again, the patient must prove that the error was the result of negligence[280].

There are several ways that Doctors and other medical professionals can make diagnostic mistakes.

- **Wrong diagnosis.** Also called *misdiagnosis*, this is when the doctor picks the wrong illness. For example, a doctor diagnoses a patient with a gastric problem when in fact the patient was having a heart attack. Or, the doctor diagnoses cancer when the patient is cancer-free.

[280] *ibid*

- **Missed diagnosis.** The doctor gives the patient a clean bill of health, when in fact the patient has an illness or disease.
- **Delayed diagnosis.** The doctor eventually makes the correct diagnosis, but after significant delay. Late diagnosis is one of the more common types of diagnosis error.
- **Failure to recognize complications.** The doctor makes the right diagnosis, but fails to identify complications or factors which change or aggravate the illness or condition.
- **Failure to diagnose a related disease.** The doctor correctly diagnoses one disease, but fails to diagnose a related disease. A related disease is one that often goes hand-in-hand with the primary condition or that has a higher risk of incidence in patients with the primary disease.
- **Failure to diagnose an unrelated disease.** The doctor correctly diagnoses one disease, but fails to diagnose a completely unrelated second disease.

4.1.2 Improper Treatment

Persons who offer medical advice and treatment implicitly state that they have the skill and knowledge to do so, that they have the skill to decide whether to take a case, to decide the treatment, and to administer that treatment. This is known as an "implied undertaking" on the part of a medical professional.

A doctor can be held liable for improper treatment only if one can prove that she/ he is guilty of a failure that no doctor with ordinary skills would be guilty of if acting with reasonable care.

Doctors must exercise an ordinary degree of skill[281]. However, they cannot give a warranty of the perfection of their skill or a guarantee of cure. If the doctor has adopted the right course of treatment, if she/ he are skilled and has worked with a method and manner best suited to the patient, she/ he cannot be blamed for negligence if the patient is not totally cured[282]. Although some treatment mistakes can be obvious (such as giving an overdose of medication), others are generally less apparent to lay people.

When a doctor makes a mistake during the treatment of a patient, and another reasonably competent doctor within the same specialty would not have made the same mistake, the patient may file a claim for medical malpractice.

In the Nigerian case of *Kanu Okoro Ajegbu v. Dr.E.S. Etuk*[283] the deceased was admitted into the Onitsha General Hospital on 16th of August 1961 by the defendant doctor who diagnosed a *niptured appendix.* He treated the deceased with antibiotics to localize the infection and perform an appendectomy on the 17th of August, (i.e. the next day), only one incision was made but it had to be extended to expose the appendix properly. On the 20th of August, the deceased was given an enema because his stomach was slightly distended. As it did not work, the nurse who gave it reported this fact to the defendant who instructed that a little more enema be given to him and that if it failed, a flatus tube should be used. The second enema again proved ineffective. Upon the doctor's further directives that a flatus tube be used if the second enema did not prove successful, flatus was then resorted to and a flatus tube was accordingly inserted and all

281 *Smt J S Paul vs Dr (Mrs) A Barkataki* (2004) 10 CLD 1 (SCDRC - MEGHALAYA)
282 *ibid*
283 (1962) 6 E.N.L.R. 196

the enema and air were discharged. The deceased later died on the 21st of August 1961. There was some evidence that the death might have been due todelayed *chloroform poisoning*.

However, no postmortem examination was conducted to establish the actual cause of death. A dependant of the deceased sued the defendant under the Fatal Accident's Act 1961, claiming damages for the death, which the dependants attributed to the negligence of the defendant. The particulars of the negligence were:

1. That there was gross negligence in the actual performance of the operation which was said to have lasted for about three and half hours and that there were incisions;
2. The defendant refused to attend to the deceased after the operation because he did not come into the hospital as the defendant's private patient; and,
3. That the deceased was overdosed with chloroform thereby, setting on chloroform poisoning.

On the first allegation, the court found that the operation actually lasted for about one hour only and that only one incision was made. The court also held that although the administration of the first enema was a negligent act, it was not the doctor that ordered it and thus, cannot be held liable for its consequences and that in any event the enema and gas were later discharged.

On the question of neglect raised in ground two the court found that it was nottrue and in addition there was the fact that there were only two doctors attached to the General Hospital, which was far inadequate.

On the allegation of poisoning through over-dosed chloroform the court found that even though there was medical evidence that the symptoms before death were consistent with delayed chloroform poisoning, the witness was not categorical on this because no postmortem

examination was conducted in order to ascertain whether or not it was the actual cause of death. It was finally decided that the plaintiff had failed to prove his allegations, where upon, his claims failed as well.

It would appear that on factual grounds there would have been a strong case against the doctor relating to poisoning by overdose chloroform had postmortem examination been conducted to ascertain the cause of death. The decision of the court in this case was proper because, it is the general principle of law that he who alleges, must adduce cogent evidence to prove. It was, therefore, the responsibility of the plaintiff to order for postmortem, to garner evidence for postmortem, to garner evidence for his case.

4.1.3 Improper Administration of Drugs

A common form negligence by Medical Practitioners comes in from of improper administration of medication. Prescription errors can have devastating impact on the health and course of treatment for the patient. Whether the nurse administers a shot incorrectly, or a pharmacist misreads the medication prescribed by the doctor's poor handwriting, the patient suffering is entitled to file a claim, alleging medical negligence against the concerned parties.

The usual improper use of drug always involves at least some remote possibility of unfavourable reaction. Not only may a patient's intrinsic allergy to the drug cause a reaction, there is also the possibility that the amount of the dosage, the mode of administration or even the speed of injection can cause an unfortunate reaction. Although, a great numberof these types of reactions are unpredictable, there are occasions when a physician, through proper medical practice, particularly, in reviewing the past history of the use of the drug can predict (foresee) the reaction to a particular drug[31].

In addition to those deriving from drug reactions, other liability situations in theuse of drugs may involve choice of the wrong drug for the patient's condition, overdosage, or infections that follow injections and results from the use of unsterilized equipments, or solutions[32].

In the Nigeria, the *locus classicus* is the Supreme Court decision of *University Of Nigeria Teaching Hospital Management Board And Others V. Hope Nnoli*[284], Mr. Hope Nnoli, was the only qualified chemist working with the U.N.T.H., an unqualified pupil chemist Nwuzor, was undergoing internship with *Hope Nnoli*. On 20th February, 1989, *Mr. Nwuzor* compounded *chloroquine syrup*, which caused the death of children aged between one and four years. A post mortem examination conducted on the bodies of the children confirmed that the cause of death was the *chloroquine syrup*. There was a public outcry and the Management Board of Teaching Hospital conducted an investigation to ascertain the person or persons involved or responsible for the overdose. It was *Mr. Nnoli and Mr. Nwuzor* who were found liable in negligence.

4.1.4 Anaesthesia

Many complications arising from central *neuraxial anesthesia*, has resulted in litigations. To claim damage here, it can be claimed that a particular anesthetic agent was given in excessive dosages, either because of the patients low tolerance or because of a failure to recognize complications demanding reduction of the dose. There are very many cases alleging complete paralysis following the use of a spinal anesthetic. Also, errors in the use of *anesthetic* gas machines have been involved in cases of*asphyxiation*. The breaking of the needle used to inject

284 [1994] 8 NWLR (Pt. 363) at 407-408 6 [1961] WNLR 173

anesthetic has given rise to claims, as have injuries to the teeth and mouth following inhalation of *anesthetic*[285].

Inherent in the *anesthetic* situation is the dreaded "cardiac arrest", where the medical practitioners are confronted with the tragic dilemma of the so-called 4 to 7 minute "eternity," within which to attempt to resuscitate the patient[286]. If such attempts bring back the body but not the mind (that is, permanent brain damage from cerebral *hypoxia and/or anoxia*), the expense involved in keeping and in maintaining such a person will be too enormous to bear. In a situation of this kind, and malpractice suit against a Medical Practitioner may run into very large figures.

In Nigeria there is the case of *Kanu Okoro Ajegbu v. Dr. E.S. Etuk*[287]. In this case, the deceased was admitted into the *Onitsha* General Hospital on 16th August 1961, with a diagnosis of ruptured acute *appendicitis* bythe defendant doctor. He developed complications and died. The dependant of the deceased sued the defendant for negligence, alleging that the operation lasted three and half hours instead of 45 minutes and that there were two incisions instead of one. They also alleged that the defendant did not attend to the deceased because he did not come in as his private patient. It was alleged that there was an overdose of *chloroform* or anesthesia and this was establishedas a matter of fact. The court, however, acquitted the defendant on procedural grounds in the sense that postmortem examination had not been conducted to establish the cause of death.

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285 R. Crawford Morris and Alan R. Moritz, *Doctor and patient and the Law*, Fifth Edition C.V. Mosby Co., Saint Louis, 1971. P. 329.

286 *ibid*

287 .(1962) 6 E.N.L.T. 196.

4.1.5 Blood Transfusion:

Claims in negligence for medical liability in blood transfusion arise in several different ways. One type of such claims arises from the use of mismatched blood. This can be caused either by laboratory errors in cross-matching or by clerical errors whereby blood intended for one patient, is given to another.

A blood transfusion is a relatively simple procedure in which donated blood is taken from one person and given to another who needs it. The donated blood is usually separated into red cells, platelets and plasma which are then used to treat different conditions[288]. The blood is given through a drip which is placed into a vein in the arm – the amount of blood given will depend on the patient. A straightforward blood transfusion can take from between one and four hours. When the transfusion is completed, the drip is removed and the patient should have their vital signs checked.

Blood transfusions are generally very safe – it is important to remember that it is very rare that errors occur. While most blood transfusions are carried out without an issue, there are mistakes that can be made, either due to clinical or administerial negligence that can have a serious and severe effect on the patient.

Negligence in blood transfusion can occur in different ways;

i. Contaminated Blood

Before a person can donate blood, they are screened for anything that might have put them at risk of infection. After donation, blood is tested in a laboratory to ensure it does not contain *HIV, hepatitis*

288 Sheldon Davidson Solicitors, Blood Transfusion Compensation Claim Solicitor https://www.sds solicitors.com/medical-negligence-claims/hospital-negligence/blood transfusion-claims/ Accessed 10th February, 2023.

or any other blood borne infection, or *parasites* before it can be approved for use. It must then be stored correctly and kept sterile before being administered to the patient[289].

The risk of catching a *virus* from the blood received during a blood transfusion is very low. However, if there is a failure at any point in the process and a patient is given contaminated blood, they may end up contracting a blood borne infection, or developing *sepsis.* Either of these occurrences can be life threatening, and if it is found that negligence is the cause, it may be possible to make a claim.

ii. Incorrect blood type[290].

It is immensely important that a patient is given the correct type of blood that matches their own, and they should be tested immediately prior to the transfusion taking place to confirm this.

iii. Fluid overload[291]

There is a risk that if too much blood is transfused, or if the process happens to quickly, that the body will struggle to cope. This can result in swelling of the body, dangerously high blood pressure, breathing difficulties and ultimately heart failure as the heart struggles to pump enough blood around the body. this tends to affect people with serious health conditions, low body weight and the elderly, so it is important that steps are taken to avoid fluid overload in these patients. If you or a relative have been affected by fluid overload as a result of a transfusion being administered too quickly, it may be possible to make a claim for medical negligence.

Other errors relating to a blood transfusion include:

289 Sheldon Davidson Solicitors, Blood Transfusion Compensation Claim Solicitor https://www.sds solicitors.com/medical-negligence-claims/hospital-negligence/blood transfusion-claims/ Accessed 10th February, 2023

290 *ibid*

291 *ibid*

iv. carrying out a blood transfusion unnecessarily[292]

v. administering a blood transfusion to the wrong patient[293]

vi. errors caused due to lack of care or attention[294]

In Nigeria one *Mr. Ude Oche*, engaged the services of a solicitor who wrote in April 1998 to the Ahmadu Bello University Teaching Hospital Management, claiming a sum of ₦2.5 Million, being special and general damages, as a result of negligence and breach of duty in blood transfusion leading to the death of his wife on the 23rd of December, 1997. He alleged that, following the doctors prescription for surgery, blood grouping and cross match was performed after undue delay. He expressed dismay over the apparent authority and arrogance of Mr. Andrew, the 400 level student of Laboratory technology who conducted the test, after a very considerable delay. After the test, Mr. Andrew (Lab Technologist) came up with *AB RH* positive result. But *Mr. Oche* informed the staff that the correct blood group of his wifewas *O RH* positive and not *AB RH Positive*. The Doctor, relying on the laboratory result transfused the *AB RH* positive to which the wife reacted badly. At this point, another laboratory staff was compelled to repeat the test, which confirmed *O RH* positive and not *AB RH* Positive. Although this correct group was eventually transfused, the wife never really got over the reaction until she passed away on the morning of 23rd December 1997.

In 1998, the A.B.U.T.H.'s solicitors entered into negotiation with the complainant's solicitors. A settlement out of court was reached in which the hospital paid a certain amount of money to the complainant and various disciplinary measures were meted against the hospital staff responsible for the injury.

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292 *ibid*
293 *ibid*
294 *ibid*

It is recommended that in view of the fact that the health consequences of poor blood transfusions could be fatal, medical practitioners and hospitals are advised to be very careful in selecting competent and well qualified laboratory technicians. This will avoid or minimize the rampant suits in negligence arising from blood transfusions.

4.1.6 Surgery

Liabilities of surgeons could arise pre-operatively, during the operation and post-operatively. Tortious liability can arise in case of negligence of a surgeon treating a patient. A patient who has been injured during an operation in a hospital may not be able to identify which one or more of the team of surgeons, *anesthetists*, nurses, and so on, are involved in the operation, was careless.

It was held in *Cassidy vs. Ministry of Health*[295] that, in such a situation, the hospital authority will be vicariously liable, unless it can show that there was no negligent treatment by any of its servants. It is usually better for an injured plaintiff to join the hospital (master) as a defendant because; it is richer than any of its servants and will be in a better position to pay than the servant (provider).

Instances of negligence during surgery may occur in different forms, for example, leaving foreign bodies in the patient, such as sponges, gauze, needles, instruments and *swabs*, gives rise to the a considerable number of claims. In suchcases, the courts apply the doctrine of *Res Ipsa Loquitur*, under which negligence can be proved by circumstantial evidence. What the Maxim of *Res Ipsa Loquitor* actually means is that the plaintiff does not know what caused the damage but people can see for themselves the cause of the damage. That was exactly what happened in the

[295] Cassidy vs. Ministry of Health [1951] 2 K.B. 343

case of *Igbokwe vs. University College Hospital, Ibadan*[296], where a lady who just had a baby and was diagnosed *psychotic* jumped from the 4th floor of the building to the ground and died. A nurse was supposed to have been with her but she stayed away enabling the patient to stray out and jumped to death. That was an actual case of *Res Ipsa Loquito*. In an action brought against the hospital, and the Hospital Board of Management the court found for the husband as it was a typical case of *Res Ipsa Loquitor*.

Other reported cases of *Res Ipsa Loquitor*, are; the case of *Mahonne vs. Osborne*[297] where an abdominal operation and some *swabs* were left in the patient. Others include- *Mrs. Rhoda Fadipe vs. UITH*[298] where some *gauze* was left in the abdomen of the patient and *Fish vs. Kapur*[299], where a dental extraction resulted to a fracture of the jaw.

The proof that the breach caused a particular damage is absolute and the burden of doing it lies with the plaintiff. In the case of *Ojo vs. Gharoro and UBTH*[300] , where the appellant had a surgical operation for the removal of a growth in her fallopian tube, because she had been unable to get pregnant. It was ascertained medically that the removal of the growth might make it possible for her to get pregnant. The surgical procedure was done by the 1st respondent and assisted by the nurse and the 3rd respondent. The appellant's alleged that in the course of the operation, the surgeon left a broken needle in her womb, resulting in very severe pain for which she claimed damages in this action. *Tobi, J.S.C.* dismissed the appeal and made important pronouncements saying that the only witness who gave evidence for the appellant is the appellant

296 (1961) NWLR 173
297 (1939) 2 K.B. 14
298 Suit No.KWS/2/2001
299 (1951) 2 K.B. 343
300 (1968) 1 ALL ER 1068

herself. She did not call any expert witness for her evidence and so her evidence struggled for the place with the expert evidence of 3 witnesses for the respondents.

Surgical mishap is a common phenomenon of medical negligence in Nigeria, leading to numerous surgical deaths. Observation has revealed that a wide range of problems, including poor or absent documentation, deficiencies in essential services, surgeons operating outside their specialty and the use of poorly trained and supervised *locum* are causes of surgical deaths.[301]

4.2 PROOF OF MEDICAL NEGLIGENCE:

The issue of proof is always key to the success of every action before a Court of law. A particular cause of action will fail to be regarded as a cause of action properly so called, if the action is not capable of being proved. Every contested case, civil or criminal, must give rise to at least one contested issue of fact, but many cases of both kinds- civil or criminal - give rise to several issues of fact to be decided between the parties[302]. These issues or disputes of fact, can only be resolved by credible evidence from each party seeking to establish a particular fact or claim before the Court. The issue of evidence is therefore at the heart of litigation.

As has been aptly noted[303], medical negligence is easy to allege, but extremely difficult to prove. For a patient to proof medical negligence, he or she must lead medical evidence sufficient to satisfy the burden of proof on him. Unfortunately, this medical evidence is usually not available. The "conspiracy of silence" of Doctors among other factors contributes to this difficulty, coupled with the fact that most times that this negligence occurs, the patients are not even conscious to observe and recount their ordeal in Court.

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301 D. Giesen, *International Medical Malpractice Law* (Mohr & Martins Nijhoff, 1988), p. 13.

302 Allen, C., *Practical Guide to Evidence*, 2nd *Ed.* (London: Cavendish Publishing Ltd., 2001) at Pg. 99

303 *Ibid*

Proof of medical negligence consists of the burden and standard of proof in medical negligence cases, the requirement of pleading particulars of negligence, and the various pieces of evidence that are not only relevant in proof of medical negligence, but which are the most viable pieces of evidence that can be used by a litigant.

BURDEN AND STANDARD OF PROOF

The 'burden of proof' is the obligation which rests on a party in relation to a particular issue of fact in a civil or criminal case, and which must be 'discharged', or 'satisfied', if that party is to win on the issue in question." The Supreme Court also recently defined the term "burden of proof[304]".

In the case of **Okoye v. Nwankwo[305]**. the Court held as follows: The term 'burden of proof', also known as 'onus of proof', refers to the legal obligation on a party to satisfy the fact finders, to a specified standard of proof, that certain facts are true. The facts for this purpose are facts in issue, the facts on which the legal rights and liabilities of the parties to the case depend[306].

The apex Court further stated that: The phrase 'burden of proof' is used to describe the duty which lies on one or other of the parties, either to establish a case or to establish the facts upon a particular issue[307].

Burden of proof is two-fold, *viz*:

i. The first is the ability of a plaintiff to establish and prove the entire or reasonable portion of his case before a Court of law that can give judgment in his favour. This is always constantly on the plaintiff.

304 Allen, C., *Practical Guide to Evidence*, 2nd *Ed Ibid*
305 (2014) 15 NWLR (Pt. 1429) 93 S.C
306 *Ibid* p. 133, paras. A-C
307 *Ibid.* paras. D-C

ii. The other type is related to particular facts or issues which a party claims exist. It is this burden of proof that oscillates from one party to the other.

While the first type of burden of proof is called legal burden of establishing a case, the second one is called evidential burden[308].

Generally, the Evidence Act 2011 makes copious provisions on the burden of proof in cases. It provides in *Section 132* that the burden of proof in a suit or proceeding, lies on that person who would fail if no evidence at all were given on either side. The Act further provides that whoever desires any Court to give judgment as to legal right or liability dependent on the existence of facts which he asserts, must prove that those facts exist[309], and that when a person is bound to prove the existence of any fact, it is said that the burden of proof lies on that person.

The Act made further provisions with respect to the particular burden of proof in either civil or criminal cases. It provides that in civil cases, which this work is concerned with, the burden of first proving existence or non-existence of a fact, lies on the party against whom the judgement of the Court would be given if no evidence were produced on either side, regard being had to any presumption that may arise on the pleadings[310].

In the case of **Okusami v. A. G., Lagos State[311]**, the Court stated that:

> By virtue of Section 135(1) of the Evidence Act, the burden of proving the existence or non-existence of a fact in civil cases lies on the party against whom the judgement of the Court will be given if no evidence is produced on either side, regard being had to any presumption that may arise on the pleading.

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308 Amupitan, J. O., *Evidence Law: Theory and Practice in Nigeria*, (Lagos: Innovative Communications, 2013) at Pg. 821-824

309 Section 131, Evidence Act 2011

310 Section. 133, *Ibid*

311 (2015) 4 NWLR (Pt. 1449) 220 at p. 248, paras. D-E.

Also, Section 134 of the Evidence Act further provides that the standard of proof in civil cases shall be discharged on the balance of probabilities in all civil proceedings. The standard of proof refers to the degree of probability facts must be proved to be true[312]. This trite position was recently upheld by the Supreme Court in the case of ***Uwah v. Akpabio***[313], where the Court held that "civil suits are decided on balance of probabilities; put differently, on the preponderance of evidence*".*

It follows from the above, that in a medical negligence suit, it is for the patient-complainant to establish his claim against the medical man and not for the medical man to prove that he acted with sufficient care and skill. If the initial burden of negligence is discharged by the claimant, it would be for the hospital and the Doctor concerned to substantiate their defence that there was no negligence.

The patient in an action for medical negligence must discharge this burden of proof on him by leading credible evidence to proof his case.

4.3 Civil Liability

When health care providers are alleged to have failed to observe the legal principles and standards concerning the care of patients, civil litigation may result. The most common and potent basis of civil liability for medical malpractice cases is negligence[314]. Thus, where a health care provider administers treatment to a patient negligently and injury is caused to the patient, he may sue for negligence against the provider for the injury suffered. The *rationale* for liability for

312 *Ibid*

313 (2014) 7 NWLR (Pt. 1407) 472 at p. 489, paras. B-D

314 *Ibid*.

negligence of a health care provider is that, someone harmed by the actions of such a provider deserves to be compensated by the injuring party.

In law, a plaintiff must establish three elements in order to succeed in an action for medical negligence. The elements include:

a. that the health care provider owed the plaintiff a legal duty of care;

b. that the provider was in breach of that duty;

c. that the plaintiff suffered injury/damage as a result of the breach.

4.3.1. Legal Duty of Care

A health care provider owes a duty to a patient. Thus, if he undertakes to care for, or treat a patient, whether there is an agreement between them or not, he owes that patient a duty of care. He does not owe a duty of care to anyone who needs *aid* and who can be reasonably assisted,[315] rather he owes the duty to a patient he has undertaken to care for/treat, whether there is an agreement between them or not. The question is what is meant by a duty of care? "Duty" simply means that obligation recognized by law to take proper care to avoid causing injury to another in all circumstances of the case.

In *Hedley Byrne & Co Ltd v Heller & Partners Ltd*[316], Lord Morris noted as follows**:**

"It should now be regarded as settled that if someone possessed of a special skill undertakes quite irrespective of contract, to apply that skill for the assistance of another person who relies upon such skill, a duty of care will arise…"

Again in *R v Bateman*[317] the court explained that:

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315 C. O. Okonkwo, "*Medical Negligence and the Legal Implications*" cited in B. C. Umerah, *MedicalPractice and the Law in Nigeria* (Nigeria: Longman Nigeria Ltd., 1989), p. 123

316 [1957] A. C. 555.

"…if a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient or client, he owes a duty to the patient or client to use due caution, diligence, care, knowledge and skill in administering treatment…"

Therefore, where a patient relies on the skill and knowledge of a provider with respect to his/her health, a duty of care arises. Providers owe a duty to give adequate counseling to patients, to warn patients of the risks involved in the medical treatment being offered, to conduct a proper examination and to make proper diagnosis; duty to administer injections, *anaesthesia*, x-rays, *etcetera* properly, to avoid wrongful treatment, to see their patients or clients, to inform patients adequately, etc.

Similarly, hospital authorities owe the same duty of care to patients accepted for treatment in their hospitals. In America and other jurisdictions where "Good Samaritan Laws" exist, if a nurse or doctor freely offers services to someone in an emergency situation, he would not be held liable if anything goes wrong.[318]

Thus, a nurse who hears a neighbour's shout for help, because she is delivering her baby in the staircase, and offers her services, would not be exposed to civil liability if something goes wrong; it is the same in the case of a doctor who renders help at a scene of a road accident. However, this "Good Samaritan Law" does not apply in Nigeria. Rather, the health care provider in such cases will be held liable to the degree of care of a reasonable health care provider in the circumstance.

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317 1935] 94 K.B. 791.

318 . C. O. Okonkwo, "*Medical Negligence and the Legal Implications*" cited in B. C. Umerah, *MedicalPractice and the Law in Nigeria* (Nigeria: Longman Nigeria Ltd., 1989), p. 124

4.3.2. Breach of Duty of Care

Breach of duty means that a defendant's conduct fell below the required standard expected of him. A health care provider will be in breach of the duty he owes a patient or client if he fails to exercise the standard of care, which the law expects of him. For the health care provider, the standard is that of the ordinary, reasonable health care provider with the skill of the defendant.

The fact that a *mishap* occurs does not establish negligence on the part of the provider as long as he followed the approved procedure for the treatment offered. There must be some form of standard against which the conduct of the health care provider has to be examined that is the standard of a reasonable, skilful health care provider of the same experience, placed in the same circumstances. It is noteworthy that the standard is relative, that is, in each circumstance, the standard will be judged by factors as time, place and availability of facilities.[319].

For instance, if a provider acts under emergency conditions, where he may act without the necessary equipment, the standard expected of him may be lower than that of one acting under normal conditions. But this is no excuse for a provider who knows that facilities are unavailable and inadequate, to undertake treatment under such conditions, especially when there is a nearby hospital or medical centre with necessary facilities.

Similarly, the standard of care expected from local providers in villages cannot be in accordance with current trends in some urban areas like Lagos, where there has really been a lot of technological development. In the case of *Warnock v Kraft* [320] it was explained that:

> A doctor in a small community or village not having the same opportunity and resources or keeping abreast of the advances in his profession, should not be held to the same standard of care and skill as that employed by physicians and surgeons in large cities…

[319] B. A. Susu, *Law of Torts*, (Lagos: CJC Press Nigeria Ltd., 1996), p. 155.

[320] (1938) 85 p. 2nd 505 in Susu

Even a house officer is not expected to show the same standard of skill and care as a registrar or a consultant who is a specialist in a particular area. It is pertinent to note that, a doctor, nurse, *anaesthetist*, or any other health care provider, who holds himself out to a patient as possessing special skill and knowledge in a particular area of health care, must exercise the same degree of care and skill as those who generally practice in that field. A nurse who undertakes a complicated *In-Vitro Fertilization (IVF)* surgery must conform to the standard of a qualified obstetrician. If not she will be liable in negligence for undertaking such treatment with full knowledge that as a nurse, she does not have the special skill and knowledge and facilities required for that type of surgery. Thus, the standard of care is that of the member of the skilled group to which she holds herself as belonging. The more skill and knowledge you hold yourself as possessing in the profession, the more the standard of the professional with such skill you will be held to have.

A chemist who holds himself out to be a pharmacist will be judged as if he were a pharmacist[321] It is apparent, therefore, that the test is the standard of the ordinary skilled man exercising and professing to have that special skill which is not part of the ordinary equipment of the reasonable man.[322]

In *Bolam v. Friern Hospital Management Committee*,[323] the court said:

> But where you get a situation, which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill; neither that of a specialist of perfection; nor that of one with Olympian reputation, but an average yardstick of reasonableness and objectivity. A man need

321 *Kelly v. Carrol* (1950) 219 p. 2nd 79 A.L. R. 2nd 1174.
322 *Blyth v. Birmingham Water Works* (1856) 11 Ex, 781
323 [1957] 1 WLR 582 at 586.

> not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

It should be noted that members of various professions, from their own expertise and experience, have practice standards or guidelines by which their disciplinary authorities determine and measure the competence and standards by which providers have performed their various tasks. The consequence of having such practice standards is that, providers who fail to comply with them, may be held to be in breach of their duty.

In Nigeria, for example, the *Medical and Dental Practitioners Act*[324] regulates the medical and dental professions. This Act sets up the Medical and Dental Council of Nigeria. The Council listed acts constituting professional negligence to include, making mistake in treatment, failure to advise or proffering wrong advise to a patient, making incorrect diagnosis, failure to attend to a patient, etc[325]

In the case of one Mrs. Olabisi Onigbanjo, decided by the Medical and Dental Practitioners Disciplinary Tribunal (M.D.P.D.T.)[326], surgical drape in the abdomen of the woman after surgery, was found guilty. He was suspended from practice for six months.

Apart from the disciplinary action which may be taken against the medical practitioner by the Medical and Dental Council of Nigeria, or by an employer, for negligently performing his duties below the practice standards, the courts can of course use those standards to measure such a provider's duty of care. The court may hold a provider liable because he has performed below those standards. But, for the court, compliance with those standards does not necessarily mean that the legal standards have been satisfied. The court, at the end of the day, sets the standards,

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324 Cap M8, Laws of the Federation of Nigeria 2004.

325 *Rule 28, Code of Medical Ethics in Nigeria, Revised ed, (Medical and Dental Council of Nigeria, 2004), p. 41*.

326 R. Abati, "Health Care and Negligent Doctors"; *The Guardian Newspaper*, Tuesday 4th January 2005

and "may find that the standard of practice the profession has set is unacceptable to the wider community."

In every case, the law requires that the health care provider's conduct must not fall below expectation or standard. Therefore he must always act like a reasonable, skilful and competent provider in order to avoid liability.

4.3.3. Proof of Damages.

In an action for negligence, when a plaintiff has proved existence of duty of care and its breach by the health care provider, he must prove that he suffered damage as a result of the breach in order to succeed and be compensated. This remedy is recognized by law in order to assuage the feelings of the injured plaintiff. But, it must be shown that the health care provider's breach of duty, as a matter of fact, caused the damage. That is to say, that the plaintiff must show a causal link between the damage he suffered and the provider's act. In *Ajaegbu v. Etuk,*[327] the plaintiff was unable to establish that the damage suffered was as a result of the breach of duty by the medical practitioner.

The onus of proof lies with the plaintiff, and usually, if a provider does not admit negligence in a given case, then the plaintiff will have to call evidence to show negligence on the part of the provider i.e. to show that the conduct of the provider fell below the required standard in a particular case. Such evidence which assists a plaintiff and even the court in determining that a provider acted below the required standard of care is primarily the testimony of experts, which in turn relies on learned treatises, articles in medical journals, research reports, etc. Expert evidence is used because it is only a health care provider who can show that another health care provider in the same field acted below the required standard. The problem encountered here, however, is

[327] (1962) 6 ENLR. 196

the reluctance of these providers to give the needed expert evidence, because they do not want to blame or expose a colleague.

According to Okonkwo, this silence is sometimes referred to as the "conspiracy of silence"

In *Hatcher v Black*,[328] Lord Denning stated that:

> It would be wrong, and indeed, bad law, to say that simply because a misadventure or mishap occurred, the hospital and the doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining a patient or a surgeon operating at a table, instead of getting on with his work, would be forever looking over his shoulder to see if someone was coming up with a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action in negligence can wound his reputation as severely as a dagger can his body"

As true as the above statements are of doctors and probably of other health care providers, yet if a provider's mistake or error of judgment can be shown to be the result of a breach of duty, which has caused damage to a plaintiff, he should not be allowed to escape liability. In other words, if damage would not have occurred but for a provider's act, then his act caused the damage and he should be liable. On the other hand, if the damage would have occurred despite the provider's act, then his act did not cause the damage and he should escape liability.

In *Barnett v Chelsea and Kensington Hospital Management Committee*[329] the claimant's husband and two of his fellow night watchmen went to the hospital and complained that they had been vomiting for three hours after drinking tea. The nurse called the casualty doctor by telephone and told him of the complaint. Instead of going to see them, the doctor instructed the nurse to tell them to go home and consult their own doctors later. This was an error of judgment and a breach of the doctor's duty of care. In any case, the men left and later that day the claimant's husband died of arsenic poisoning, and the coroner's verdict was that of murder by persons unknown (arsenic was introduced into the tea). The court, however, found the

328 *Black v. Hatcher,* CV420-177

329 [1969] 1 Q.B. 428.

doctor/hospital in breach of duty, but the breach was not a cause of the death because, even if the deceased had been examined and treated with proper care by the doctor, it would probably have not been possible to save his life. Thus, there was no causal link between the negligent act of the doctor and the injury eventually suffered by the claimant's husband. The claimant's case failed.

4.3.4. Causation and Remoteness of Damages.

Causation is a formidable hurdle for plaintiffs in medical negligence litigation as there are great uncertainties in the medical world regarding the causes of many adverse conditions. This means in trying to proving the negligence, causation in not east to prove as nothing in the medical is certain for sure. In the Nigerian context, injured patients find it very difficult to obtain expert witnesses. If the doctor or hospital can raise question as to causation, the patient often is in no position effectively to challenge them. The basic principles in negligence litigation, the plaintiff much establish not merely that the defendant owed and breached a duty of care to the plaintiff but also that such breach caused "materially contributed to" or increased the risk of the injury of which of the plaintiff complains. This, in that broad sense, a causal connection must be established between the tortuous act of the defendant and damage which the plaintiff suffered. The importance of causation in negligence cases has been captured by the Court in the case of **A.N.T.S v. Moloye**[330],in the following words:

> Causation as a fault-finding or fault placing mechanism whether in criminal law or in the law of torts has an element of fluidity in practical application to a given situation as it lacks specific fixation. It does not therefore serve useful purpose to seek a precise test. The most acceptable criterion is to identify first the factor or factors but for which the damage complained of should not have occurred and then select what appears to be the most responsible cause. By and large, the selection process is not a matter of law but one of common sense borne out from the rich experience of human interaction in society, tailored to the facts and

330 (1993) 6 NWLR (Pt. 278) 233

circumstance of the case with a view to arriving at what is essentially a value judgement.

The causal requirement of factual causation is generally determined by a reference to a conventional "**But for"** test principle. If the injuries that the plaintiff sustained would not have occurred but for the defendant's tortuous act, the causal requirement would be fulfilled.

The standard test for proving causation is the '**but for'** test, e.g. 'but for the negligent medical treatment, the injury to the claimant would not have occurred: Therefore, the claimant must show their injury was caused by the negligence and that the loss or damage they suffered would not have occurred had the negligence not occurred. If the injury, loss or damage would have occurred in any event, despite the negligence then the medical negligence claim will fail. It is for the Claimant to prove this 'on the balance of probabilities'. This means it must be proved that it is more than 50% likely the injury was caused by the alleged negligence.

A classic example is in the context of medical negligence action was the case of ***Barnett v Chelsea &Kesington Hospital***[331]**.** The plaintiff was the widow of a man who died of arsenic poisoning from contaminated sandwiches. After he had attended the defendant's hospital and negligently be sent home without treatment. The deceased was a night-watch man working over New Year's Eve. The nurse on duty informed the casualty officer of the man's condition, but the casualty officer who suspected that the man had simply over-indulged on New Year's Eve instructed the nurse to inform the plaintiff return home and come back on another occasion. The man was admitted to hospital later that morning. After considerable delay but died sometime later. The question examined by the court was whether the deceased would have died had the defendant acted without negligence and admitted him earlier. The court was of the opinion on the basis of evidence that even if the defendant had acted with due cares and admitted the deceased;

331 (1969) 1Q.B. 428

he would still have died of arsenic poisoning as the poison had already irretrievably and fatally taken its hold. **Niel J** in deciding causation, stated;

> "But that, since he must have died of the poisoning even if he had been admitted to the wards five hours before his death and treated with all care, the plaintiff had failed to establish on the balance of probability that the defendant's negligence had caused the death".

Thus the defendant's conduct was not the cause of the death of the deceased.

Also, in the English case of **Wright v. Cambridge Medical Group**[332], the Court of Appeal held that where there are successive tortfeasors, the contention that the causative potency of the negligence of the first is destroyed by the subsequent negligence of the second depends very much on the facts of the particular case. It further held that, in many cases where there are successive acts of negligence by different parties, both parties can be held responsible for the damage which ensues, so that the issue is not which of them is liable, but how liability is to be apportioned between them. The mere fact that, if the second party had not been negligent, the damage which subsequently ensued would not have occurred, by no means automatically exonerates the first party's negligence from being causative of that damage.

In this case, the claimant contracted chickenpox when she was eleven months and developed a high temperature and tachycardia, and was admitted to the defendant hospital. Within a couple of days, the claimant developed a bacterial super-infection with streptococcus pyogenes, which the hospital had not diagnosed by the time of her discharge. The expert evidence established that the bacteria seeded into the proximal femur (i.e. that part of the hip-bone closest to the trunk of her body), resulting in *osteomyelitis* (i.e. infection of the bone), which caused permanent injury to the plaintiff. She suffered permanent unstable hip, restricted movement range, leg length

[332] (2011) EWCA Civ.669; (2013) Q.B 312

discrepancy, and restricted mobility. The claimant instituted the action claiming that the failure of the hospital to diagnose her condition on time or in the alternative to refer her to another hospital, caused her the permanent injury she suffered, which contention the Court accepted in finding the hospital liable in negligence.

Causation is the relationship that must be found to exist between the tortuous act of a defendant and the injury to the plaintiff in order to justify compensation of the latter out of the pocket of the former. The plaintiff has the burden of proving, on a balance of probabilities that the defendant caused or contributed to the injury. Our Courts have consistently and recently reaffirmed that the general test for causation is that which requires the plaintiff to show that the injury would not have occurred "but for" the negligence of the defendant. The test requires the plaintiff to establish on a balance of probabilities that the defendant's tortuous act was a necessary cause of his or her injuries. There are difficulties in the application of this test. The Courts have recognized that the criteria used by scientists to determine whether or not damages are probably related to a particular cause are, occasionally, at odds with common sense and experience. There are cases in which the negligent act of the defendant has made it impossible for the injured party to prove causation. There are cases in which the ability to prove or disprove causation rests particularly with one party. There are cases in which it is impossible to prove whether or not a negligent act, which created a risk of injury, actually caused the resultant injury. In attempting to apply the general principles to such cases, the Courts have identified circumstances in which the strict application of the "but for" test, or application of scientific standards of certainty in the application of the test, would result in an injustice. As a result our courts have been prepared to draw an inference of causation from "very little affirmative evidence" and have identified exceptions to the "but for" test with a view toward avoiding injustice.

In Fairchild v Glenhaven Funeral Services[333], the claimants suffered from *mesothelioma* after inhaling asbestos fibres. Unlike asbestosis, it is impossible to medically prove when the disease was contracted because of the way it develops. Each defendant denied liability on the basis that it could not prove whose asbestos made the critical contact with the claimant. The House of Lords extended McGhee and found that on the balance of probabilities, each defendant's breach of duty had materially increased the risk of the claimant contracting mesothelioma. It was enough to show that the asbestos exposure any defendant was responsible had contributed materially to the risk of harm. This case was very much a policy decision, as the Lords found that the injustice caused by denying compensation to employees who suffered terminal harm outweighed the potential unfairness in imposing liability on employers who could not be proved to cause the harm. The Fairchild approach provides fairness on the part of the claimant where it is impossible to pinpoint the exact cause of harm. This is to the detriment of the defendant, who may be ordered to pay compensation for harm that he is not responsible for, but the interests of justice dictate that the claimant should receive some compensation. The cases following Fairchild appear to be contrived so that a claimant can succeed. This makes it difficult for case outcomes to be predicted, as judges tend to rely on policy reasons rather than legal principle to justify their decisions.

In ***Armstrong, Carol Ann (executrix of the estate of Peter Traynor, deceased and on behalf of the dependents of Peter Traynor, deceased) v Quest Laboratories Pte Ltd and another***[334], a 5-judge Court of Appeal reversed the trial judge's finding that the negligence of a medical laboratory (Laboratory) and a pathologist, Dr T (Respondents), had caused MrTraynor to lose four years of his life. Instead, the Court of Appeal held that but for the respondents' negligence,

[333] (2002) UKHL 22

[334][2019] SGCA 75

MrTraynor would have been fully cured of his metastatic melanoma, and damages should be calculated on the basis of MrTraynor's full life expectancy. In September 2009, MrTraynor consulted his general practitioner about an unusual mole on his back. A specimen of the mole was sent to the laboratory for an examination and preparation of a pathology report. Dr T, a pathologist from the laboratory, returned a pathology report indicating no malignancy. Two years later, in December 2011, MrTraynor discovered a lump under his right armpit. A biopsy of his axillaries lymph nodes revealed metastatic melanoma. The specimen from MrTraynor's mole taken in September 2009 was also re-examined by another pathologist, whose pathology report carried the diagnosis of "malignant melanoma with ulceration". Despite repeated medical procedures and several rounds of chemotherapy, MrTraynor passed away from metastatic melanoma in December 2013 at the age of 49. The suit was brought in 2015 by MrTraynor's widow (Appellant) as executrix of his estate and on behalf of their two daughters (as dependants).

The trial judge held that the question of breach was straightforward in this case, sending Mr. Traynor a pathology report with a clean bill of health when the circumstances required (at the very least) further examination was, in the trial judge's view, a clear case of negligence. What was less clear was the issue of causation. The trial judge noted the appellant's argument that the cancer had not spread beyond the armpits until after 2009. An earlier diagnosis would have resulted in surgical removal of the lymph nodes and arrested the spread of the cancer. As to the staging of the cancer as at 2009, which was also a contested issue, the appellant argued that based on her experts' staging of the cancer, Mr. Traynor would have had at least a 68% and closer to 80% chance of survival. Conversely, the respondents claimed that Mr. Traynor's fate had been "biologically determined" even before the misdiagnosis. They argued that prior to

September 2009, the melanoma had already distally *metastasised*, but remained dormant and undetectable until later on. Since the course of Mr. Traynor's melanoma was already biologically determined, so to speak, the Respondents argued that they ought not to be held liable for his demise. The trial judge was not fully persuaded by either side. While the trial judge thought that the respondents' breach had caused Mr. Traynor to "lose a fighting chance", the trial judge did not accept the appellant's statistical evidence that Mr. Traynor would have at least a 68% chance of surviving 10 years. The trial judge took heed of Lord Nicholls' dissent in the English case of Gregg v Scott[335], where Lord Nicholls had urged courts to "leap an evidentiary gap when overall fairness plainly so requires". The trial judge's leap over the "evidentiary gap" in this case was in estimating that since Mr. Traynor had survived almost four years after his misdiagnosis, he might have lived twice that number had he been properly diagnosed. Thus, the trial judge found that the respondents' negligence had caused Mr. Traynor to lose four years of his life.

The Court of Appeal agreed with the trial judge's views on the respondents' breach. Turning to the causation question, the Court of Appeal disagreed with the trial judge's approach, and accepted the appellant's argument that but for the respondents' negligence, Mr. Traynor's melanoma would have been cured completely. The Court of Appeal was convinced on the balance of probabilities that Mr. Traynor's fate was not already "biologically determined" at the time of misdiagnosis in 2009. Furthermore, the Court of Appeal was persuaded that Mr. Traynor would have availed himself of curative treatment through a sentinel lymph node biopsy which would have revealed the microscopic melanoma metastasis in the lymph nodes, followed by completion lymph node dissection. This would have completely cured Mr. Traynor of his melanoma.

335 [2005] UKHL 2

In coming to the conclusion that the appellant had proven her case on the balance of probabilities, the Court of Appeal undertook a lucid and systematic examination of all of the available evidence, much of which involved medical and scientific information of a very technical nature. In so doing, the Court of Appeal observed that there was a tendency in medical negligence cases to focus overwhelmingly on the statistical evidence presented. A careful appreciation of what statistical evidence means and how it should be applied is necessary. It followed from the Court of Appeal's findings that the appellant's damages should be calculated on the basis of Mr. Traynor's full life expectancy, and not on the basis that Mr. Traynor had only lost four years of life. Within those parameters, the Court of Appeal remitted various questions on damages for the trial judge's consideration.

Closely tied to the issue of causation in the law of tort, is the principle of remoteness of damages. Remoteness of damage, also known as legal causation, is the means of approaching whether the defendant should be held liable, even where the "but for" test may be met. The rule emphasizes that a defendant must not be held liable for damage which was too 'remote' the cause of the damage or injury.

In a system of fault liability, which depends upon foreseeability of the damage as a test of the defendant's breach of duty, it may seem unfair to hold the defendant responsible for all the damage that his negligence has caused, even where the damage is of a different type or occurred in a different manner from that which would normally be expected.

There are two broad approaches to the problem of remoteness.

The first takes the view that a defendant is liable for all the direct consequence of his negligence, no matter how unusual or unexpected. The second holds that a person is only responsible for

consequences that could reasonably have been anticipated, even where he has undoubtedly caused the damage in question.

It is now trite that reasonable foreseeability is the basic requirement not only for the existence of duty of care and its breach, but also for remoteness of damage[336].

The most apt rules regarding the question of remoteness of damage. Accordingly, they include:

- Intended consequences are never too remote, for intention to cause injury disposes of any question of remoteness. This is because people who are either foolish or mischievous must be made answerable for consequences which common-sense would in all direction attribute to their wrongdoing.
- Where the consequences are unintended, it is no excuse that though some consequence was intended, the particular decree of the consequence which was produced was not intended. For instance, where the victim is a high income earner or the property damaged is of intrinsic value, the defendant cannot argue that he never expected the loss to be so great[337].
- **The "egg-shell, skull" principle**: Propounded by Kennedy J., in ***Dulieu v White***[338] He stated that if a man is negligently run over or otherwise negligently injured in his body, it is no answer to the sufferer's claim for damages, that he would have suffered less injury or no injury at all, if he had not had an unusually thin-skull or unusually weak heart. This means the defendant must be held liable for the whole damages suffered to that extent but

336 Quin v Leathern (1901) A.C. 495
337 Vacwell Engineering Co. Ltd. v B. D. H (1971) 1 Q. B 88
338 (1901) 2 K. B. 669

for the existence of physical weakness or other attributes unknown to the defendant. The rule of foreseeability here is that you must take your victim as you saw him[339].

- The defendant cannot answer for the plaintiff's impecuniosities; hence where the plaintiff incurs extra loss due to poverty, the defendant cannot be liable.
- ***Novus actus interveniens***: As noted in the preceding pages of this work, where an independent event intervenes or interrupts or breaks the chain of causation and results in damage to the plaintiff, the defendant will escape liability as his breach will be held to be too remote the cause of the damage.[340] This intervening activity may be by third parties in which case the defendant will be absolved of liability. Where the intervening activity is from the plaintiff, the plaintiff will be held to have contributed to the injury he suffered and liability is distributed on the basis of contributory negligence between the plaintiff and the defendant.

Finally, it is apposite to state that the Court can decide on the issue of remoteness of damages whether or not the parties specifically pleaded and relied on same. This was the holding of the Court in the case of ***Chaguary v. Yakubu***[341] where the Court held as follows:

> Once issues are joined on liability for and quantum of damages payable, the Court can, in considering the issues joined, decide whether or not the damages are remote irrespective of whether or not either of the parties pleaded remoteness of damage. The issue of remoteness of damage is not like special damages which must not only be pleaded but strictly proved.

From the foregoing, the plaintiff in an action for medical negligence must prove all ingredients of the tort of negligence, to *wit*, that there exist between him and the defendant-Doctor, a duty of care which duty was breached by the defendant, and that the breach of duty resulted or directly

339 Smith v. Leech Brain & Co. Ltd (1961) 3 All E.R. 1159; and Robinson v. Post Office(1974) 1 WL 1176

340 Lamb v. Camden Borough Council (1981) K. B. 625

341 (2006) 3 NWLR (Pt. 966) 138 at p. 169, paras. H

caused the injury suffered by the patient, and which breach was not too remote a result of the breach of the Doctor. The patient must proof these ingredients by leading credible evidence in proof of his case on the balance of probability.

Proof of Negligence: *Res Ipsa Loquitur*

The burden of proving negligence rests with the plaintiff, and if, at the conclusion of evidence, it has not been proven on a balance of probabilities, that the defendant was negligent, the plaintiff's case fails.[342] The plaintiff, who suffers injury, must therefore prove affirmatively that his injury was caused by the carelessness of the defendant.

At times, the establishment of the relevant evidence may be very difficult for the plaintiff, that is, to show that some specific act or omission of the health care provider was negligent. This is so, because the plaintiff is most likely to be a layman, and medical science is a very specialized area. He may not, therefore, know or understand what actually happened. Consequently, he needs to call expert evidence; if not, he will find himself going through an impossible burden of proof and in the end will fail to establish what in truth, is a valid claim. More so, the judge will also have to rely on expert evidence to decide the case, as he may lack the knowledge or even the experience to be able to draw the appropriate inferences. For example, he may not know the standard required in a complicated surgical operation or the required composition of the ingredients for a particular drug. Only medical experts will know. The judge would, therefore, need expert evidence too. Unfortunately, as already noted, these health care providers are usually reluctant to testify against fellow providers. All these are obstacles that hinder prosecution of cases against them.

342 *Adeoshun v Adisa* [1986] 5 NWLR (Pt. 40) p. 225.

Justice would not be done if the plaintiff is allowed to go without a remedy because of the difficulties encountered in proving his case. Though the plaintiff may not be in a position to locate the exact act or omission that caused the injury, and the defendant alone may know, the plaintiff is assisted by the doctrine of *res ipsa loquitur*. This is a Latin expression, which means that "the thing speaks for itself".

The entire doctrine was stated in *Scott Osuigwe v Unipetrol*[343] thus: Where the thing is shown to be under the management of the defendant or his servant, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence in the absence of explanation by the defendant that the accident arose from want of care…" Once the plaintiff can show that the thing that caused the damage was under the management or control of the defendant or his servants, and the accident was such as would not ordinarily have happened if proper care was taken, the court will infer negligence against the defendant. The plaintiff will no longer be called upon to prove negligence on the defendant's part because; the surrounding circumstances amply raise an inference of negligence. The onus of proof then shifts to the defendant, which if not discharged, will lead to his liability.

In cases of *res ipsa loquitur*, the plaintiff is saying he does not know how the damage occurred. If he knows, the maxim will not apply. The doctrine therefore only applies when looking at a set of facts, which the plaintiff cannot explain, the natural and reasonable inference to be drawn from them is that what has happened was the result of some act of negligence on the part of the defendant.

343 [2005] 5 NWLR (Pt. 918) 261

4.4 Criminal Liability

Criminal law obviously applies to health care providers, and the purpose of criminal prosecution is to punish the offender. In Nigeria, criminal law codes apply, that is, the Criminal Code which applies in the Southern States, and the Penal Code, which applies in the Northern States as well as the Federal Criminal Code[344], and Federal Penal Code.[345]

If health care providers in their practices become grossly negligent causing bodily harm, or reckless in the care of others, they will be liable in criminal proceedings. Section 303 of the Criminal Code provides that, it is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act; and such a person by reason of any omission to observe or perform that duty. An anesthetists was found guilty of manslaughter where he caused the death of a patient due to his gross negligent in attention during surgery.[346]

It follows, therefore, that if a health care provider does not use reasonable care, or his conduct falls below the standard of care required by law, he is said to be negligent. This means that, if he does not use reasonable care or he negligently performs his duties and thereby causes the death of a patient, he is guilty of manslaughter. However, his negligence or incompetence must be so great as to show a disregard for life and safety and to amount to a crime against the state, and conduct deserving punishment.[347]

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344 Criminal Code Act, Cap. C38, Laws of the Federation of Nigeria 2004

345 Penal Code (Northern States) Federal Provisions Act, Cap P3, Laws of the Federation of Nigeria, 2004

346 *R. v. Adomako* See *R. v* [1944] 3 All E. R. 78 (HOL, England)

347 See *R v. Bateman* (1925) 133 L.T. 30 at 732, (1925) 133 L.T. 30 at 732, in Okonkwo and Naish , *Criminal Law in Nigeria,* (Ibadan: Spectrum Books Ltd, 2003) p. 250

Consequently, for criminal liability, the degree of negligence required of health care providers is that it should be "gross" and not "mere" negligence. In *Kim v State*[348], the Supreme Court held that the degree of negligence required in the medical profession to render a practitioner liable for negligence is that it should be gross and not mere negligence, and that the court cannot however, transform negligence of a lesser degree into gross negligence by giving it that appellation. The court referred to and followed the case of *Akerele v R*[349]. Here, the accused, a qualified medical practitioner administered injections of a drug known as *Sobita* to children as a cure for yaws. A number of children died, and he was charged with manslaughter of one of the children. The case of the prosecution was to the effect that the accused had concocted too strong a mixture and thereby administered an overdose to the deceased, amounting to gross negligence. He was found guilty of manslaughter and sentenced to imprisonment for 3 years. *WACA* upheld the conviction, but the accused further appealed to the Privy Council which held that the negligence of the accused did not amount to gross negligence and allowed the appeal. According to the court, "It must be remembered that the degree of negligence required is that it should be gross, and that neither a jury nor a court can transform negligence of a lesser degree into gross negligence by giving it that appellation.

Thus, the health care provider owes to his patient or client a duty of care not to act grossly negligently.

By section 343 of the Criminal Code,

(1) Any person who in a manner so rash or negligent as to endanger human life or to be likely to cause harm to any person:

(e) Gives medical or surgical treatment to any person whom he undertakes to treat; or

348 [1992] 4 NWLR (Pt. 233) p. 17

349 [1942] 8 WACA 5

(f) Dispenses, supplies, sells, administers, or gives away any medicine, or poisonous or dangerous matter; is guilty of a misdemeanor, and is liable to imprisonment for one year.

While this section creates the offence of misdemeanor for negligent act which only endangers human life or is likely to cause harm to another person, *Section 303* of the Criminal Code creates the offence of manslaughter for grossly negligent acts which cause death.

Therefore, the punishment in criminal proceedings instituted against a health care provider may be imprisonment or fine or both. So long as negligence, whether it causes death or not, is not of such a high degree or is not gross as to be sufficient to convict for manslaughter, the charge should come under *Section 343* of the Criminal Code. It is the same where an act that is grossly negligent does not result in death. Here, one cannot be convicted of manslaughter, but may be conveniently convicted under *Section 343.*

It is noteworthy that the degree of negligence which the prosecution must prove to establish the offence of manslaughter differs in cases of misdemeanour. Although the negligence which constitutes the offence of misdemeanour must be of a higher degree than the negligence which gives rise to a claim for compensation in a civil court, it is not of so high a degree as that, which is necessary to constitute the offence of manslaughter[350].

An individual who is unskilled may decide to act as a health care provider. Such a person cannot excuse his act by saying that he did his best, if his best fell below the required standard of care. For instance, if a carpenter holds himself out as a doctor and performs an operation on another person, he will be expected to show the average competence normally possessed by qualified medical doctors. He will be guilty of the consequence of falling short of that standard. This is because the law requires him to possess the requisite skill and to use it. He will, in any case, be

[350] *Dabholkar v R.(*1948) AC 221 at 224-225

guilty of an offence involving negligence only if his conduct is negligent. It is the same in the case of a nursing sister, who runs a maternity home, parades as a doctor, and performs a caesarean section on a pregnant woman, who subsequently dies by bleeding to death. Obviously, she does not have the knowledge of a qualified surgeon. Therefore, she acted in an incompetent manner in reckless disregard for the life and safety of the woman. She will be found guilty of the consequences of her act.

The activities of quacks, in the area of healthcare, have taken a toll on the lives of many Nigerians, especially the women folk. The courts, therefore, seem to punish them seriously for their negligent acts in order to discourage them. In the case of *State v. Okechukwu*[351], where a quack was sentenced to nine years imprisonment for manslaughter, the court noted as follows:

> I would stress that the incidence of medical quackery has been a cankerworm which must be stamped out if lives of innocent citizens must be protected from sudden and unnatural death. It is extremely dangerous for an ignorant mountebank like the accused to dabble in medical science for which he is least qualified. This type of offence is very common nowadays and a deterrent sentence is called for in this case. Ignorant persons should not be allowed to experiment with lives of others

In spite of decisions like this, the activities of quacks continue to increase. It seems that if greater punishment like life sentence is given to them, they will definitely be deterred from carrying on with their deadly activities.

In Section 343(1) of the Criminal Code[352]provides that any person who in a manner so rash or negligent as to endanger human life or to be likely to cause harm to any other person.

A. gives medical or surgical treatment to any person whom he has undertaken to treat or

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351 (1965) E.N.L.R 91

352. Cap C38: Laws of the Federation of Nigeria 2004

B. Dispenses, supplies, sell, administer, or give away, any medicine, or poisonous or dangerous matter is guilty of a misdemeanor and is labile to imprisonment for one year.

The offence here is a misdemeanor and the degree of negligence which will ring about a conviction is not as high in a prosecution for manslaughter which is of a stiffer punishment. Criminal liability cases are rare and this is because criminal law seeks to punish and stigmatize people and society generally finds any criminal act reprehensible and damaging. It kills generally the confidence of other doctors and if used very often will not be of benefit to the society as doctors and even specialist might object to undertaken risks for the sake of their patient.

Where a registered medical practitioner or dental surgeon is convicted by any court in Nigeria or elsewhere which has the power to award imprisonment for an offence within the opinion of the medical and dental council is incompatible with the status of a medical and dental practitioner whether or not such an offence is punishable with imprisonment, particular conviction (s) such may afford a ground for the striking off the practitioners name from the register of the medical and dental council of Nigeria[353]

4.5 Defenses for Medical Practitioner Liability.

In medical professional liability, cases or suits, the burden of proving legal liability of the medical practitioner rests upon the patient. This means that the evidence presented by the patient must be convincing than that presented by the physician. The Physician is presumed to be free from liability until the contrary is proved. The patient must sustain the burden of proof with respect to the essential allegations of his claims against the medical practitioner. If he charges the practitioner with professional negligence, for example he has the burden of establishing the standard of care applicable to the physician, and of proving the practitioner's failure to conform

[353]. Code of medical ethics in Nigeria 2004 page 68.

to that standard of care[354]. Even where the patient-plaintiff has discharged himself of the necessary burden of proof, the medical practitioner may still not be liable in medical mishap if it can be shown and successfully pleaded that the medical practitioner has a defence to his claim

A Medical Practitioner accused of Medical Negligence is entitled to a number of defences in Law. Such defences include but not limited to:

4.5.1 Contributory Negligence.

This defence is available to health care providers. If the plaintiff's own negligence leads to the damage he sustains, in whole or in part, it is known as contributory negligence. The term contributory negligence has been defined by *Kodilinye* as, "the negligence of the plaintiff himself, which combines with the defendants negligence in bringing about the injury to the plaintiff"[355] Contributory negligence is want of care by a plaintiff for his own safety, which contributes to the damage while also the defendant's fault partly contributes to the damage. The court will reduce the damages recoverable, so that the plaintiff will not recover in full. The purport of Contributory Negligence remains that where any party suffers damage as the result partly of his own fault and partly of the fault of any other person or persons, a claim, in respect of that damage, shall not be defeated by reason of fault of the person suffering the damage, but the damages recoverable in respect thereof shall be reduced to such extent as the court thinks just and equitable, having regarded to the share of the claimant in the responsibility for the damage[356].

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354 *Ballance v. Dunnington 24/Mich. 383 217 N.W 329 (1928).*

355 Kodilinye G. *Nigeria Law of Torts*. Spectrum Law Publishing, Ibadan, 1990, P.83.

356 *Section 234 of Anambra State Torts Law 1986 and other Torts Law of various states.*

The onus is, therefore, on the defendant to raise the defence of contributory negligence[357]. He does not have to show that the plaintiff owes him a duty of care, rather, he has to show that the plaintiff has failed to take reasonable care for his own safety in respect of the damage in question, and that by reason of this, the plaintiff contributed to his own injury. The standard of care expected of the plaintiff is the same as that in negligence itself, the same reasonable man's test is applicable to him. With respect to apportionment of damages, the judge in appropriate cases would reduce damages to such an extent as he thinks just and equitable, having regard to the share of the claimant in the responsibility for the damage[358]. There is no mathematical formula for this.

An example of contributory negligence is where a plaintiff actively disregards warnings or fails to take reasonable steps for his or her safety, and then assumes a certain level of risk in a given activity.[359] Another example of contributory negligence is where a patient fails to follow instruction to return for further treatment[360]. If the damage suffered by the plaintiff is partly as a result of the plaintiff's own fault and partly the result of the defendant's fault, then the plaintiff is guilty of Contributory Negligence and does not recover damages in full.

One of the most commonly used defenses to negligence claims is to show contributory negligence on the part of the plaintiff. Contributory negligence occurs when a plaintiff's conduct falls below a certain standard necessary for the plaintiff's protection, and this conduct cooperates with the defendant's negligence in causing harm to the plaintiff. In plain English, this means the plaintiff most likely would have avoided injuries had he or she not also been negligent. At Common law, contributory negligence was a total or complete defence, that is, it afforded the

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357 *NRC v Emeahara & Sons* [2012] 2 NWLR (Pt. 352) 206

358 *Section 234 (1) Anambra State Torts Law, 1986 and other Torts Law of various states*

359 Contributory Negligence- Wikipedia, the free encyclopedia https://en.m.wikipedia.org/wiki/contributory_negligence >accessed on 17th February, 2023.

360 *Gerber V Day, (1931) 119 Cal. 535*

defendant complete freedom from liability. So if the medical practitioner was negligent and the patient himself contributed to the negligence occasioning his own injury, he was entitled to nothing by way of damages.

In *Crossman v Steward*[361] the plaintiff was held to have contributed to the defendants Negligence. The defendant in that case had prescribed a drug for the plaintiff's skin disorder without warning her that there was risk involved in prolonged use of the drug. The plaintiff continued to use the drug for a long period after the defendant has stopped prescribing it.

4.5.2. Defence Of Consent.

Most medical practitioners stand to rely on the defense of consent where there are allegations against them for medical negligence, alleging that the patient consented to the treatment but forgetting the fact that the patient only consented to proper management of sickness. Notwithstanding, consent obtained by fraud or under the influence of drugs or anesthesia is not consent. Consent must not be obtained by threat of violence or by influencing unduly, the patient's will. A Medical Practitioner who relies on consent as a defense will plead *Volenti non fit injuria.*

Volenti non fit injuria is a Latin maxim which means "injury cannot be done to a willing person" it's a common law doctrine which states that if someone willingly places themselves in a position where harm might result, knowing that some degree of harm might result, they are not able to bring a claim against the other party in tort.[362] Literally, it means no injury is done to a person who consents. Consent is to give agreement or permission. It is concurrence of will,

361 (1977)5 C.C.L.J. 45

362 Lisa Esamah LE, *Medical Negligence in Nigeria* www.academia.eduvolentinonfitinjuria> accessed on 17th February, 2023.

voluntary yielding of the will to the proposition of another[363]. In the case of *Ndubuisi v Olowoake*[364] it was held that

> '*Volenti non fit injuria* represents the axiom that one that consents to injury cannot be heard to complain of it thereafter. Thereafter means where a grievous harm or any damages has been done to the plaintiff if he consents to the doing of such act, he has no remedy in tort…"

In professional medical liability, it is a cardinal legal principle that one who knowingly enters upon a course of conduct involving certain risks cannot recover damages for injuries resulting from the conduct. In medical professional liability suits, the defence of consent applies to the risk of injury from medical treatment performed with proper care, but it does not apply to risk of negligent medical treatment if the patient had no reason to expect such negligence. Where an adult patient insisted that his fractured arm be re-broken and reset despite opposition and warning by his physician the patient assumed the risk and could not recover damages when he subsequently lost the use of his arm.[365]

A patient, who knowingly, entrusts himself to the care of someone lacking in medical qualifications, assumes the risks arising from such lack of qualifications. Where a patient who had been using drugs for a longtime to control his epilepsy submitted herself to the care of a chirographer knowing that the chirographer did not believe in the use of drugs, the patient assumed the risk of adverse effects from discontinuance of the use of drugs.[366]

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363 *Blacks Law Dictionary H.C. 6th Edition (1990) Page 1033*

364 (1997) 1 NWLR (Pt. 512) page 325 -336

365 *Gramm. V. Boener 56 Ind. 497 (1877).*

366 *Kirschner v. Keller 70 Ohio. App. 111, 42 N.E. 2d 463 (1942)*

It is a general rule that a medical practitioner cannot avoid liability for negligence by having a patient sign in advance a release or a contract containing an exculpatory clause. The obligation of a physician to possess and exercise reasonable care in treating a patient is imposed by law.[367]

The essential element of *Volenti non fit injuria* in Negligence case is that the defendant must show not merely that the plaintiff consented that is, by agreement express or implied to physical risk but must equally show that the risk is Legal. This is the only condition that can exonerate the defendant from liability[368]

Consent is a complete defence to an action in negligence if the patient with full knowledge, voluntarily accepts the risk of injury.

Scope of the Consent.

Informed consent.

Informed consent simply means that a patient who is matured and who is able to take decisions based on sound reasoning must be fully and sufficiently informed about the purpose, nature and the implications of the medical treatment to be administered on him, including the risks involved, so that he may chose whether to go in for it or not[369].

Therefore, what is needed is not consent per say, but genuine and informed consent. Especially in the case of dangerous application of novel and incompletely tried methods of diagnosis or cure. Consent is no defense unless it is given to the precise treatment or operation or at least to acts of a substantially similar nature, with awareness of all the risks involved.

The extent of the medical practitioner's duty to inform and enlighten the patient regarding any possible harmful effects increases proportionately as the intervention, as viewed by a prudent

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367 *Walden v. Jones 289 Ky. 395,158 S.W.2d 609 (1942*

368 Ibrahim Imam, *Synoptic Guide on the Law of Torts.* (A handbook) 2001 Pg 45 & 46.

369 Daniel E. Hall, *Informed Consent For Clinical Treatment*, Canadian Medical Journal (cmaj) 2012 Mar 20; 184(5): 533–540.

patient, is less necessary nor urgent. Thus, it is possible that in some cases the physician should also enlighten the patient regarding improbably risks, if an intervention is not necessary, or other less dangerous ways of treatment that exist. This applies particularly to aesthetic operations, where the physician must refuse his services even when the patient, not only consents to, but insists on a dangerous intervention not sufficiently justified by the patient's interest[370].

Physicians frequently fail to make a full disclosure to patients concerning the proposed treatment or operation. Unless this is necessary in the interest of the patient's health, half-truth or "soft answers", may mean negative consent from the patient[371]. This means that, a doctor may exercise therapeutic privilege if he thinks that revealing a particular risk would be adverse to the patient's health[372]. In *Sidaway v. Board of Governors of the Bethlem Royal Hospital* (1985) A.C. 871. The plaintiff had pain in her neck, shoulder and arms. A neuron-surgeon examined her and recommended an operation. What the plaintiff was told is not clear, as the surgeon had died by the time of the trial. The operation carried out with a 1 % risk of damage to the spinal cord and a 1-2% risk of damage to nerve roots. The surgeon had apparently told the plaintiff about the risk of damage to the nerve roots but not of that to the spinal cord. The operation was carried out without negligence by the surgeon but the plaintiff was severely disabled as a resulted damage to her spinal cord. The House of Lords held that the surgeon had followed approved practice of *neuro-surgeons* in not disclosing the risk of damage to the spinal cord and was not negligent.

The majority of the House (Lord Scarman dissenting) was prepared to accept a modified version of *Bolam* test for the giving of information. The major modification was that, where the judge thought that where disclosure of a particular risk was obviously necessary but it was not medical practice to disclose, then following standard practice would not avoid liability. The example

370 Fleming On Torts. PP. 114-115.
371 Smith v. Auckland Hospital Board (1965) N.Z.L.R. I91(C.A.)
372 Canterbury v. Spence (1972) 464 F 2d 772

given was a 10% risk of a stroke. If medical practice was not to disclose of the risk, then a court would import this decision to the effect that, where the court considers that a particular piece of information was necessary, failure of the medical practitioner to disclose in exercise of therapeutic privilege will not be accepted, even if his action is in line with current medical practice. This is especially so because the patient's right to know the risk involved in the treatment is based on self-determination. A doctor will therefore, only have defences of therapeutic privilege if disclosure would have posed a serious threat of psychological detriment to the patient.

A surgeon, charged with a particular operation, is not also justified in departing from instructions and performing a different one, except in an unanticipated emergency, calling for an immediate decision to save life or preserve health. But in cases involving the discovery of an unforeseen serious condition during an operation which requires departure from the intended procedure or extension of treatment *or* operation the issue whether the surgeon has authority to proceed or whether or not is decided on several criteria, especially on whether an emergency existed or the extension was necessary .

Where a patient, before undergoing an operation specifically asks the surgeon about the risk involved then he is bound to disclose fully. Thus, in *Smith v. Auckland Hospital Board*[373] , the patient before undergoing exploratory procedure, specifically asked one of the physicians concerned whether there was any risk? The physician did not answer the question directly but in effect reassured the patient, although some risk materialized and the patient lost his leg.

Evidence from other physicians showed that, although they would not, in like circumstances volunteer information as to the risk to the patient, they would tell him of it if specifically asked. In the circumstances the Court of Appeal upheld the Jury's finding that it was negligent for the

[373] (1965) N.2.L.R. 191 (C.A.)

defendant physician not to have where harm is caused he may be liable in negligence or both in trespass to the person and in negligence[374]. Generally, when the result of some treatment is poor patients' solicitors prefer to allege unauthorized treatment or surgery rather than attempt to prove negligence, which is more difficult.

Requirement For A valid Consent:

For an informed consent to be validly obtained, the following requirements must be complied with, that,

a) The person who gave the consent must have had the requisite capacity to do so,
b) The consent must have been given based on knowledge of what is to be done and the repercussions;
c) The need to obtain fresh consent where the need arises for an operation or treatment entirely different in nature from that which consent was originally obtained, and
d) There must not have been any fraud in obtaining the consent.

i. **Capacity To Consent**

Capacity to consent here means, the ability in law, to freely and voluntarily consent to a treatment or operation being carried out on a patient having disclosed the nature of the treatment or operation, the material and psychological consequences in terms of risks and the dangers involved. With regard to the capacity of a patient to consent, he must be or age. If he has not attained the age of majority, then such a valid consent can only be obtained from his parents or guardians or next- of- kin. There is no certainty as to what constitutes the age of majority in this regard. However, it would appear that if someone has attained the age of 18 years he may give a valid consent or if he has attained such an age that it could be presumed that his mind and brains

374 Diana Woss M, *Consent To Medical Experimentation*, Journal of Medecine, Science And Law, 2005 P. 89.

are developed enough to have a general understanding of matters and be able to take decisions on them[375].

If the operation or the treatment is to be conducted on a patient shows age is below 18, and that operation is not for his own benefit or someone who related to him, his consent and that of his parent must be obtained and such consent must not be given where the operation is totally of no benefit at all to the patient[376]. Where the patient is of age and therefore, can give valid consent, then the consent of his parent alone is not a license for the doctor to go ahead and start treating him or to withhold treatment on him. The patient must consent himself, except where the patient is incapable of consent because of unconsciousness or other defective state of mind; otherwise, the physician will be liable in assault and/or battery or negligence; as the case may be[377].

Where a patient is mentally deficient his ability to give a valid consent will depend on the degree or extent of his mental ailment, if the mental illness is such that could impair someone's ability of proper perception then the consent of his parent or guardian is necessary but if it is not up to that level he may then give his proper consent for admission and treatment in the mental hospital[378], the patient is married, then the other spouse may give consent on his o her behalf, if his or her condition is such that he or she cannot himself or herself give a valid consent[379].

ii. **Knowledge As A Requirement For A valid Consent**

For consent to be valid, the patient must have been fully informed about the kind of treatment or operation to be perform, the risk involved, the benefit of such a treatment or operation to him and the alternative opened to that kind of treatment. Consequently a general consent obtained from

375 *Ibid*
376 *Ibid*
377 *Ibid*
378 *Ibid*
379 *Ibid*

the plaintiff if not enough for this purpose. A general consent here means, a consent given for treatment or operation without advance knowledge of the risk and dangers involved.

This is at variance with the doctrine of informed consent and therefore, unacceptable in medico-legal ethics. The patient in this regard, has the option of instituting an action in the tort of battery or in negligence against the medical practitioner. If he elects to sue in battery, then the issue of proving negligence will be immaterial because battery is actionable per se, that is, without proof of damage. If prefers' an action in negligence, then he must prove it, by pleading successfully, the ingredients of negligence. Thus, in the American case of *Bowers v. Talmage and Von storch*[380], a nine year old boy, who was suffering from hallucinations was taken to the defendants neurologist who being in doubt whether the druids trouble was emotional or organic, recommended ; Arteriogram, an exploratory process in which three percent of cases are known to result in serious injury. There was no emergency that would warrant the performance of the operation. The defendant did not explain the dangers of the treatment to the child's parents but they gave their consent anywhere. The plaintiff was paralyzed as a result of the treatment. In an action, it was held that "unless a person who gives consent to an operation knows it dangers and the degree of danger his consent does not represent a choice and is ineffectual"

Unlike the American courts that appear to be in favour of the patients as far as the disclosure doctrine before consent is valid is concerned English courts seem to operate in favour of the medical practitioners. Thus, in England if a doctor, in exercise of therapeutic privilege, is of the opinion that informing a patient of the risks and dangers involved in a treatment or operation will be detrimental to his health or psychology them unless that opinion of his is not in line with the generally accepted practice in the medical profession, he may not be liable unless the patient himself can prove that if he were properly informed, he would not have submitted himself to that

380 (1936) 50 2d.

treatment or operation. Thus in case of *Hatcher v. Black*, the plaintiff[381], a singer, suffered from a diseased thyroid gland. She them underwent a *thyroidectomy* after being assured by the surgeon that there was no risk to her voice. A nerve was no badly injured in the operation that the plaintiff's voice was damaged. The doctor knew there was slight risk to the plaintiff's voice but refused to inform her about it in order that she should not get worried. The doctor was held not negligent because his action did not fall short of the standard of a reasonably skilful surgeon. Nevertheless, the House of Lord, although maintaining the principles above has brought in, some slight modification. Thus, in *Sidaway v. Board of Governors of Bethlem Royal Hospital*[382]. The plaintiff, had pain in her neck, shoulder and arms. A neuro-surgeon examined her and recommended an operation. What the plaintiff was told is not clear, as the surgeon had died by the time of the trial. The operation carried with it a 1% risk of damage to the spinal cord and a 1-2% risk of damage to the nerve roots. The surgeon had apparently told the plaintiff about the risk of damage to the nerve roots but not that to the spinal cord. The operation was carried out without negligence by the surgeon but the plaintiff was severely disabled as a result of damage to her spinal cord.

The House of Lords held that the surgeon had followed approved practice of *neuro-surgeons* in not is closing the risk of damage to the spinal cord and was no negligent. The House of Lords, however, ruled that where the judge though that disclosure of a particular risk was obviously necessary but it was not medical practice to disclose, the following standard practice by a medical practitioner will not avoid liability.

What this simply means is not whether or not, standard medical practice will avail a medical practitioner for withholding information before carrying out an operation or treatment, will

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381 1985) A.C. 871

382 *Sidaway v. Board of Governors of Bethlem Royal Hospital Ibid*

depend on the discretion of the court. And this discretion is to be exercised, taking into consideration all the circumstances of the cases.

With respect to the position where the patient specifically asks questions, it is not clear. In *Sidaway v. Board of Governors of Bethlem Hospital*[383], Lord Bridge was of the view that there is a duty to answer as truthfully and as fully as the questioner requires.

However, in *BIyth v. Bloomsbury Health Authority*[384], the Court of Appeal said that there was no duty to pass on all the information available to the hospital. The reply would be satisfactory if it confirmed to standard practice.

It is submitted that a reasonable man would hesitate to undertake hazardous treatment, and therefore, unless therapeutic reasons contra indicate, doctors should always make simple, quiet but honest disclosure commensurate with the risks in all cases and let the patients choose what risk or risks to run with their bodies. Where for therapeutic reasons, it is medically and legally unethical to inform the patient of the risks or dangers involved in the treatment *or* operation, a responsible relative of the patient should be inform on the patients behalf and obtain his or her informed consent, before embarking on any treatment or operation. Beside, informing the patient or a close and responsible relation of the risks or hazards involved in an operation *or* treatment it should always be insisted that a consent in writing in which the patient or someone on his or her behalf acknowledges this explanation. This procedure is in place in some hospitals in Nigeria especially, the Ahmadu Bello University Teaching Hospital, Zaria.

iii. The Need to obtain fresh consent on an issue entirely different from the one earlier consented to.

383 *Ibid*

384 (1987)5 PN167, 162.

The question to be asked and answered here, is what happens, if in the course of an authorized treatment, a medical practitioner encounters a condition, constituting a threat to the patient's life for which the patient had consented to treatment or operation?

The general principle of English Law and probably, Nigerian Law in this regard is that, if a patient's consent is given in respect to a treatment and in the course of the treatment a new case requiring treatment is found, the doctor should seek for a fresh consent from the patient or from someone on the patient's behalf, before embarking on the treatment of the new issue. In a case, *Mohr v. Williams*[385], a doctor was employed to perform an operation on the plaintiff's right ear but after anaesthetizing her and examining her and finding that the condition was not serious in the right ear as he supposed, but found a more serious condition in the left ear went ahead to operate. He was held liable in battery despite the fact that the operation was successful, and skillfully performed since it was not in emergency situation. This implies that at Common Law, and as well as under Nigerian Law, the right of a physician to extend an operation beyond that authorized by the patient, is limited to emergencies calling for immediate action. An emergency has been defined as a medical situation such as to render immediate treatment advisable either to save life or to safeguard health.

Therefore, if in the course of an authorized treatment, a doctor encounters a condition constituting a threat to the patient's life he may take such steps as may be indicated by good medical practice to correct the condition and remove the treat[386]. The courts are even giving a more liberal interpretation to the work "emergency" in situations where a medical practitioner or a surgeon followed good medical practice in extending an operation beyond that originally authorized, even though the additional procedure could not properly be characterized as life

385 (1905) 104 N.W. 12.

386 *Robinson v Wirts, 387 Pa. 291,127 A.2d 706 (1956)*

saving[387]. This position of the law is good in the sense that there could arise a situation where in the course an operation a surgeon comes across a problem which needs to be tackled immediately and neither is the patient in a conscious state to consent to the new situation nor are the relatives close by, to be contacted for their consent. Without the above exception, the duty of the doctor may be seriously interrupted to the detriment of the patient's health and life. That exception to the general principle of informed consent is highly commended.

It should noted that, the Common Law rule was developed before the discovery of anesthesia, when the patient, if conscious could be called upon during the operation to consent to any medically advisable extension of the operation. Because of this, modern progressive courts are departing from the rigidity of the Common Law. They express the more enlightened view that the instances in which a surgeon may extend an operation without the express consent of the patient are not confined to emergencies. Under this view, the surgeon is authorized to extend the operation to any abnormal condition discovered during the operation when this is advisable for the welfare of the patient and follows the approved practice of surgeons' generally[388]. This position is good in the sense that it will encourage self-reliant surgeons to whom patients may safely entrust their bodies and not men who may be tempted to practice defensive medicine or who may be afraid to perform their duties because of a law suit. Thus in the case of *Barnett v. Barchrach* 34 A.2d626 (D.C. 1943), the patient complained of pain in her lower abdomen, which the surgeon diagnosed as tubal pregnancy. However, when he operated, he found that the patient had a double uterus and a normal pregnancy but a very acute appendicitis. He concluded that the latter condition was responsible for her pain and removed her appendix. The patient had an

387 *King v. Carney, 85 Okla, 62, 204 P. 270 (1922)*

388 *Re Vasoo 238 App. Div 128, 263 N.Y.S. 552 (1933)*

uneventful recovery and subsequently delivered a normal child. The patient's husband refused to pay the surgeon's fee for the reason that the appendectomy was unauthorized. The Court queried:

> "What was the surgeon to do? Should he have left her on the operating table, her abdomen exposed, and gone in search of her husband to obtain express authority to remove the appendix? Should he have enclosed the incision on the inflamed appendix and subjected the patient, pregnant as she was, to a general spread of poison in her system, or to the alternative danger and shock of a second independent operation to remove the appendix? Or should he have done what his professional judgment dictated...?

Here the judgment for the surgeon was affirmed on the grounds that the surgeon had operated within the scope of the consent given him by the patient. Secondly, the surgeon removed what he believed to be the cause of the patient's pain, which was the essential reason for which the surgeon was engaged.

It is, therefore, submitted that where the need for extension of operation arises even where there is no emergency and it is totally impossible and impracticable to obtain a fresh consent to deal with the fresh issue, the surgeon should be allowed to dispense with the need for a fresh consent and goes ahead to deal with the matter, provided the effect will be to achieve the purpose for which the surgeon was engaged.

Here, the new operation should be located within the previous consent. This will be advantageous to the health and safety of the patient and will also protect the medical practitioner from financial and other material losses, arising from unscrupulous patients or their wardens.

iv. **Consent Must Not Be Tainted with Fraud.**

Fraud here simple means intentional misrepresentation, which is deceit. A medical practitioner is under a duty to disclose to the patient the true consequences, that is, the risks and dangers, involved, whenever surgical, therapeutic, or diagnostic procedures and treatment, to be embarked

upon, include more than the hazards that the patient might normally expect, A physician should not misrepresent facts on a particular operation or treatment to his patient or his guardian in order to get their consent. He should try as much has he can, to explain to them in detail all the issue involved in the operation and their consequences. Thus, the doctor should not, for instance, under the pretext of treating a woman for one illness, perform an operation on her to cause abortion[389]. Any fraud on the part of a medical practitioner in obtaining consent renders the informed consent null and void, and the practitioner may be liable for an action in assault, battery or negligence.

4.5.3 Defence of Acceptable Practice.

Another defence that medical practitioners usually rely on is the defence of acceptable practice. The choice of accepted medical practice as to the criterion governing the disclosure of risks which supports the view that a doctor owes no duty to warn of normal risks, such as infection, and those created by anesthesia which are inherent in any surgical procedure and the view that a doctor's clinical assessment of the patient's condition may justify the withholding of information in the patient's interest.

The emphasis placed by the law on compliance with accepted professional practice might likely act as a disincentive to innovation that might prove beneficial to the society. The law balances the conflicting interests in this area by a departure from accepted practice as not itself constituting negligence, but requiring the practitioner who chooses to experiment to justify his actions by recourse to the reasoning which underlined them.[390]

389 Journal of Medicine, Science And Law *Ibid*

390 Eric Okojie, *Professional Medical Negligence In Nigeria*, (Faculty Of Law University Of Benin Journal Publication) 2011 Page 4

4.5.4 Statute of Limitation.

It is the policy of the law in Nigeria to require a person who is injured by another to seek legal redress as soon as possible. A delay in doing so may result in an injustice since the passage of time makes proof of the factual events more difficult. For all states in Nigeria have established time limits for filing suit tort. Nigeria, there is no specific statute applicable to medical professional liability suits. Consequently, a suit charging a medical practitioner with professional negligence is usually regulated by the general statutes of limitations applicable to torts.

Limitation of action is defined[391] , as a certain time allowed by statute for bringing litigation. This means that once the time allowed by Law for the purpose of instituting an action in respect of a particular act expires, the person intending to institute that action is debarred by law from doing so and where such an action is instituted it will be declared as statute-barred and consequently be dismissed by the court.

With regard to torts, this will mean the period within which a party who sustains injury or damage as a result of the act of another is entitled to maintain an action in court to recover damages. The laws governing this in Nigeria are the Limitation of Action Act[392], The Public Officers Protected Act[393], and the various States Edicts and Laws on Limitations of Actions.

In Adigun v. Ayinde[394], the plaintiff sued the defendants jointly and severally for ₦700,000 being special and general damages for the injury sustained by him as a result of the negligent driving of the first defendant. The injury was sustained on the 10th February 1978 while the suit commenced on the 17th of August 1981.

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391 Black's Law Dictionary
392 *Laws of the Federation, 2004*
393 *CAP P41, Laws of the Federation, 2004.*
394 *(1993) LCN/2495(SC)*

The defendants raised an objection to the suit on the grounds that the suit being founded on tort, cannot be brought against the third defendant which is an organ of the Federal Government because of the doctrine of state immunity from tortuous liability; that the second defendant, Permanent Secretary, Federal Ministry of Agriculture and Natural Resources is not a juristic person and as such, cannot be sued; and thirdly that the action being against Public Officers (1st and Second defendants), is statute barred as it was not commenced within 3 months from the date the cause of action arose in compliance with section 2 (a) of the Public Officers Protection Laws Cap. IIl, Laws of Niger State.

Counsel to the plaintiff on the other hand contended that the action is not statute barred in that negligence occurred on the 10th of February 1978, but the injury suffered by the plaintiff was continuous.

It was held on the issue of limitation of action that continuance of injury or damage means continuance of the Legal injury and not merely the injurious effects of the Legal injury. Therefore, the plaintiff should have, commenced action 3 months after the date of the accident and not after the date of his final discharge from the hospital. This position of the Law applies to medical professional liability in its entirety.

The next question is, when does the period of limitation begin to run? it would appear that time begins to run for the purpose of determining whether or not an action is within time, on the particular day the cause of action accrued[395]. However, there are certain cases in which this can be extended. One of such cases is where the injuries sustained by the victim of the defendant's negligence leads to his death. Here, the position of the law is that the computation of time shall begin from either the date on which the deceased died or on the date in which the personal representatives of the deceased became aware.

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[395] *Mercantile Bank of Nig. Plc. v. FETECO (Nig) Ltd. (1998) 2 NWLR (PT. 540) 143 at 156-157*

Other certain exceptions are enumerated in the case of *Aremo Ii v. Adehenye (2004) 42 WRN 1 at 21*, that:

> Legal principles are not always inflexible. Sometime they admit of certain exceptions. The Law of Limitation of action recognizes some exception, Thus where there has been continuance of the damage, a fresh case of action arises from time to time as often as damage is caused…

The most common exceptions to the limitation periods are:

i. In cases of fraud,

ii. Where there appears to be a mistake or error,

iii. Where an infant was involved as the time the cause of action arose,

iv. Where the party involved is in a state of unsound mind,

v. Where the legal action is regulated by customary law.

In conclusion, it would be said that, any action against a medical practitioner outside the limitation period, unless it falls under the above exceptions, will be time barred.

4.5.5 *Res Judicata*

Res judicata means that once a legal claim has been finally decided on the merits, it cannot be re-litigated between the same parties. This is known as the rule of *res judicata*. A decision on the merit is reached when it is a declaration of law with respect to the rights and duties of the parties, base upon the state of facts disclosed by the pleadings and the evidence. A judgment against one

of a number of joint tort-feasors, if satisfied, bars a subsequent suit against the other joint tort-feasors[396].

This defence is available in suits against medical practitioners for professional liability in negligence or in torts generally. A judgment in favour of a medical practitioner in a professional negligence suit is a bar to a separate suit for breach of warranty arising out of the same transaction[397], It is sometimes applied to bar a suit for professional negligence where the physician has recovered a judgment for compensation for his services, on the theory that the suit for compensation resolves the issue of physician's care and skill, even though the issue was not directly litigated[398]

4.6 Hospital Liability in Medical Negligence

Hospitals liability with respect to medical negligence can be direct liability or vicarious liability. Direct liability refers to the deficiency of the hospital itself in providing safe and suitable environment for treatment as promised. Vicarious liability means the liability of an employer for the negligent act of its employee. An employer is responsible not only for his own acts of commission and omission but also for the negligence of its employees, so long as the act occurs within the course and scope of their employment. This liability is according to the principle of 'respondent superior' meaning 'let the master answer'.

4.6.1 Vicarious Liability in Medical Negligence

Vicarious liability refers to a situation where someone is held responsible for the actions or omissions of another person. In a workplace context, an employer can be liable for the acts or

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396 Crawford Moris R : Doctor and Patient and the Law Hardcover – January 1, 1971 Pg 550

397 *Forman v. Wolfson 327 Mass, 341, 98 N.E. 2d 615 (1951).*

398 *Onley v. Cavell, 138 Cal. App. 233, 32 P. 2d 181 (1934).*

omissions of its employees, provided it can be shown that they took place in the course of their employment.

The doctrine of vicarious liability is based on the fact that if an employee, while acting in the course of his employment, negligently injures another person rather than the employee been held liable the employer will be held liable for that injury. Vicarious liability rests on the employer simply as a result of the fact that he is the employer and is deemed to have ultimate control over the employee in what is known as master and servant relationship.[399]

Vicarious liability arises when one person is held liable for the wrong done by another. This usually occurs where there is a relationship of master and servant. In the law of torts, a master is liable for torts committed by a servant in the master's employment. It is immaterial that the master had done no wrong. Doctors are the servants of the hospital or health management board which employ them. If a doctor negligently causes harm to a patient, both the doctor and the employer may be sued jointly or the patient may sue either of them. Usually, the employer is joined as a defendant because the employer is financially more viable than the servant[400] one explanation of vicarious liability is that it follows from the 'benefit and burden' principle. Employers take the benefit of the employees work, so that they should take the burden of the wrongs committed by those employees.[401]

Vicarious liability of the master arises on the primary liability of the servant. The servant is the principal tortfeasor while the master is the accessory. Thus, a plaintiff could sue both the health care provider and the hospital jointly. He may also sue either of them. The usual thing is to join the employer as a defendant. At times, the plaintiff may not be able to specifically identify which of the several servants of the master was negligent.

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399 Jeremy Stranks, *Health and Safety Law,* 3rd edition (Biddles ltd, Guildford & kings Lynn) 1998 page 21

400 Umerah B.C*, Medical practice and the law in Nigeria*, op citPg 129

401 David howarth*textbook on tort* (Butterworths ltd) 1995 page 632

For example, a patient who has been injured during an operation in a hospital may not be able to identify which one or more of the team of surgeons, anaesthetists, nurses, etc, involved in the operation was careless. It was held in *Cassidy v Ministry of Health* that, in such a situation, the hospital authority will be vicariously liable, unless it can show that there was no negligent treatment by any of its servants. It is usually better for an injured plaintiff to join the hospital (master) as a defendant because, it is richer than any of its servants and will be in a better position to pay than the servant (provider).

If a hospital authority is held vicariously liable for the negligence of a doctor, the authority may claim an indemnity from the doctor on the basis of a breach by the doctor of an implied undertaking in the contract of service to use reasonable care. But the hospital authority may not recover full indemnity, which has the authority of the English house of Lords[402] is not likely to be invoked by employers except perhaps in extreme cases because of the adverse consequence which it might have on relations between the employers and employees.

Apart from vicarious liability, a hospital, may commit a breach of duty of care, which it owes to another, i.e. a hospital may be in breach of its own duty to another; for example, where a hospital is at fault for selecting an unskilled person on its staff who conducts himself in a wrongful manner, or allowing such a person to continue in employment; or where it provides defective equipment for use by the health care providers under its employment.

4.6.2 Occupier's Liability

This deals with liability of an occupier of premises for damage done to visitors to the premises. An occupier, according to Lord Denning in the case of *Wheat v Lacon*[403] is, "a person who has a sufficient degree of control over premises to put him under a duty of care towards those who

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402 *Lister v Romford Ice and Cold Storage Co. Ltd, (1957) A.C 555.*

403 [1966] A. C. 522, 577; see also *I.I.T.A v. Amrani* [1994] 3 NWLR (Pt. 332), p. 296.

come lawfully upon his premises." A visitor is generally a person to whom an occupier has given express or implied permission to enter his premises.

An occupier owes a "common duty" of care to visitors to his premises. This "common duty" is defined in *section 238 (2) of ASTL 198658* as "a duty to take such care as in all the circumstances of the case is reasonable to see that the visitor will be reasonably safe in using the premises for the purposes for which he is invited or permitted by the occupier to be there." This common duty of care therefore requires hospitals to guard against danger, which may arise from the state of disrepair of their premises, or danger arising from ongoing activities on the land, such as construction work, or repairs. Also, it includes the maintenance of lifts, adequate lighting at night for safety reasons and also maintaining other equipment in the hospital. In *Slade v Battersea and Putney Group Hospital Management Committee*[404], a 67 year old lady visiting her husband in a hospital slipped and fell on a part of the floor of the ward where polish had just been spread, while she was leaving. Due to the fact that polish had just been spread, the floor was slippery and dangerous, and there was no sign to warn users. The woman succeeded in an action for damages against the hospital authority.

Therefore, the hospital authority owes a common duty of care to all persons lawfully on its premises to ensure that its premises are reasonably safe. If it does not fulfill this duty to the visitor, it will be liable in damages for any injury caused to a person lawfully on its premises. Such visitors include patients and relatives visiting patients, the hospital workers or employees.

4.7 Remedies for Medical Practitioners Liability

When it becomes established in a medical professional liability suit that the defendant is liable, one thing becomes obvious. That is, what remedy to the aggrieved party entitled to. The objective of medical liability suit is always to claim damages or compensation for the injury

404 *[1955] 1 All E. R. 429*

sustained. And in order to arrive at the amount and the nature of damages that the patient plaintiff is entitled to it is necessary to know whether the damages are for personal injuries or for death.

Damages are the pecuniary or monetary compensation that may be recovered in a law suit for the breach of some duty or the violation of some right recognized by the law[405]. Damages may be recovered either for breach of a contractual obligation or for a neglect of duty or an invasion a right recognized by the law: (1) nominal damages (2) compensatory or actual damages and (3) punitive or exemplary damages[406].

Nominal damages are the token compensation that may be recovered where no tangible loss or injury has been suffered or where there is no proof of the amount of the loss or injury. Such damages are awarded to vindicate the right that has been invaded, even though the circumstances do not justify an award of substantial damages[407].

Actual or compensatory damages are the monetary compensation recoverable for injury or loss suffered as the natural and probable consequence of a wrongful act or omission. They are either general or special damages.

Punitive or exemplary damages are monetary compensation over and above actual or compensatory damages awarded as a punishment or deterrent, because of the wanton, reckless, malicious or oppressive nature of the wrong committed. In a suit against a medical practitioner for professional liability the general rules with respect to damages apply. These rules vary somewhat, depending on the type of suit involved-breach of contract, negligence, assault, battery

405 David Pearce and Roger Halson Damages for Breach of Contract: Compensation, Restitution and Vindication https://www.jstor.org/stable/20185361 Accessed 19th February, 2023.

406 *Ibid*

407 *ibid*

etcetera[408].

4.7.1 Damages for Personal Injuries

Damages in a tort action are awarded in a lump sum. The award is claimed once and for all with no possibility of decreasing or increasing it later, because of changes in the plaintiff's situation.

Bodily harm is the most obvious loss in personal injury action. The loss or impairment of some parts of the body. This may be more or less psychological than physical.

As a corollary to this, the plaintiff patient must sue in one action for the totality of his losses, past, present and the future. He may not explain his cause of action by suing separately for different heads of damages. Nor can be resisting his damages being calculated or being assessed once and for all. The judge, therefore, has to make certain predictions as to what would have happened to the plaintiff in the future if he had not been injured.

Secondly, the judge may have to make predictions as to what may likely happen to the plaintiff in the future. This can only be resolved on a hunch or are based on statistical evidence61. In very exceptional cases, there cannot be a variation of the award as a result of changes accruing soon after the trial, this power is discretionary[409]. The overriding purpose of tort law is to compensate the injured party and not to punish the defendant. Hence, the overriding principle is to indemnify the victim for the loss he has incurred or suffered.

The strict application of the indemnity principle prevents the plaintiff from enriching himself through an accident.

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408 *ibid*

409 *Mitchell v. Muhholland, (1970) 2.A.E.R. 462.*

Nevertheless, full compensation is always awarded to the plaintiff. Damages for personal injuries in a medical professional liability suit are usually divided into two types:- Special and General damages.

a. Special Damages:

Special damages are compensation for expenses that are a natural consequence of the injury but are not a necessary consequence of the injury. They arise from the special circumstances of the case and the amount of the value of the injury or the loss must always be proved.

Special damages consist of out of pocket expenses and also of the loss of earnings incurred before trial. It is possible to calculate exactly what they amount to. Special damages must be specially pleaded. They seek, to effect a *"restitution in intergrum*". That is, to put the plaintiff in the position that he would have been, had the injury not been inflicted on him. It would be necessary to discuss some of the items of special damages.

The plaintiff is entitled to recover such expenses, which he has reasonably incurred up to the time of the trial[410]. They must be pleaded as special damages His prospective expenses will be estimated as part of general damages. The reasonableness is in relation to the plaintiff's condition in life and also to the amount paid. Any savings to the plaintiff, which is attributable to his maintenance at public expense, is set off against any loss of earnings. Where the plaintiff is nursed by a member of his family or friend, he is entitled to a reasonable cost of such nursing, even though he is not under any legal or moral obligation to pay the person who gives services.[411]

There are a host of other damages which are pecuniary losses arising from medical professional liability. For example, where a house wife is injured with the result that her capacity to carry out her domestic duties is impaired, she can claim damages based on estimated cost of employing

[410] *Cunningham v. Harrison (1975) Q.B. 942.*

[411] *Donnelly v. Joyce (1974) Q.B. 454.*

someone else to carry them out whether she in fact desires someone else to carry them out or to do so, is irrelevant. The plaintiff may also claim for the inability to carry out a profitable hobby, as a result of the injury. Whenever a tort causes a pecuniary loss, the plaintiff can recover in medical professional liability.

b. General Damage

General damages are monetary compensation for those items of injury or loss that are the natural and necessary consequence of the wrong and that are *implied* by the law from the fact of the injury. The monetary amount or value of the loss or injury does not have to be specifically proved by evidence. General damages are not susceptible to exact calculations. General damages are implied by the law. They include, future loss of earnings, pains and sufferings, loss of amenities, loss of expectation of life disabilities and disfigurements[412]. We shall now consider some items of general damages.

Pains And Sufferings:

A medical practitioner is liable to a patient for causing pains and sufferings[413]. However, a patient is only entitled to damages if that pain and suffering is the natural and probable consequence of the physician's negligence. Compensation is not allowed for pains and sufferings arising from the original ailment for which the patient was treated or if it following as a natural consequence of an operation performed with due care and skill.

The pains and sufferings may be actual or prospective caused by the injury of subsequent surgical operations.

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412 *Luke Nwanewu Onyiorah V Benedict C. Onyiorah & Anor LER[2019]SC.254/2008*

413 *Edward Okwejiminor Vs. G. Gbakeji* & *Anr*. (2008) 5 Nwlr (Pt. 1079). 172

A patient abandoned during pregnancy was entitled to damages against a medical practitioner for unrelieved pain suffered during child birth[414].

In the absence of any logical process for assessing general damages, the courts and statute have evolved a conventional scale or tarrif, acceptable to the prevailing sense of what is fair and equitable[415]. This does not mean that an objective standard is required or to be established in determining the amount of damages to be awarded for pains and suffering. It is usually left to the discretion of the judge.

With respect to future pains and suffering, the duration must be considered based on the patient's life expectancy at the time of the trial not his life expectancy prior to the injury.

Claims under this head cover shock and mental torment to the plaintiff's knowledge that his life has been shortened[416]. For a claim for mental anguish to succeed, there must be physical injury. Thus, in *Cooper v. National Motor Bearing & Co*[417], a patient developed *cancerophobia* in connection with negligently caused x-ray burns, when advised by another physician that cancer might result, recovery of damages for mental anguish was allowed.

4.7.2. Damages for Death

When there is a medical professional mishap resulting into death two issues arise. First of all the deceased's estate or executors may wish to proceed with a cause of action which the deceased himself would have had, had he lived and secondly, others, especially relatives may claim that they have suffered a loss in consequence of death.

If a tort has been committed in medical professional practice and the patient dies, the question is whether the cause of action survives. At Common Law, the death of a party extinguished any

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414 *Nolton v. Hamilton, 92 Ga. App. 727, 89 S.E. 2d 80S (1995).*

415 Second Schedule of Workmen's Compensation Act 2010. Cap. W6, Lawof the Federation of Nigeria, 2004

416 *Oliver v. Ashman (1962) 2 Q.B. 210*

417 136 Cal. App. 2d 229, 288 P.2d 581 (1955).

existing cause of action in tort by one against the other. This was based on the Latinism; action *Personalis Muritur Cum Persona".* But later on, the defect of the law forced on the attention of the legislature.

Because of this defect in the law, The Law Reform (Miscellaneous Provisions), Act, 1934 was passed. The 1934 Act, removed the rule that action did not survive death although the 1934 Act, allowed for the survival of the cause of the deceased person, it did not create as such, any new cause of action[418]. That is to say, the Act did not create liability. It simply preserved the deceased's subsisting action for the benefit of his estate. This statute merely legitimized or gave legislative blessing to a quite separate common law rule which provided that, "death could not give rise to a cause of action in other person," although they were dependent on the deceased. This was derived from the ruling of *Lord Ellen Borough in Baker v. Bolton*[419], the "in a civil court, the death of a human being could not be complained of as an injury."

The principle of survival of action does not create difficulties for damages accruing during the deceased's lifetime, for example, deceased was injured by a medical practitioner during an operation caused by the physician's negligence and died three months later. The estate will recover damages for pecuniary and non-pecuniary losses accruing after death. The action was not for death caused by the defendant and so the defendant needed not be responsible for the death. But where the defendant's wrong had caused the death, then any losses or gains to the estate consequent on the death are ignored in the calculation of damages[420]. An example of a loss would be the termination of annuity and an example of a gain would be an insurance payment. One exception to this one is that, the court may award the estate any funeral expenses incurred.

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418 *Section 1 (1) of The Act*

419 (1808) 1 Camp.193

420 *Section 1(4) of the Law Reform (Miscellaneous Provision) Act, 19934.*

It has become a settled law today in Nigeria that death can give rise to a cause of action. The applicable law is the Fatal Accidents Act[421]. The death of a patient arising from a negligent medical treatment or operation can now create a cause of action. This action for death is an action which is entirely new in its quality, new in its principle and in everywhere new.

The death of a person is caused by the wrongful act, neglect or default, and the wrongful act, neglect or default is such as would, if death had not ensued, shall be liable to an action for damages, notwithstanding the death of the person injured.

The provision is indicative that the death of a person can give rise to a cause of action that is entirely new.

a) It must be shown that the plaintiff caused the death of the deceased wrongly. That is to say, the death must have been negligently or through the default of the defendant.
b) The deceased must have died as a result of the injury inflicted upon him by the wrongful act of the defendant.
c) That if the plaintiff had not died, he would himself had been entitled to maintain that action to recover damages suffered. If the deceased had accepted any sum, while he was alive, in full satisfaction of his claims against the defendant, his estate cannot succeed in an action for his death, thereafter. If the deceased was found to be in contributory negligence, that would cause a reduction of the recoverable damages by the plaintiff.

421 CAP 18, LFN 2004

CHAPTER FIVE

COMPARATIVE ANALYSIS OF TORTUOUS LIABILITIES OF MEDICAL PRACTITIONERS IN THE UNITED KINGDOM, SAUDI ARABIA AND SOUTH AFRICA.

5.1 Tortuous Liabilities of Medical Practitioners in the United Kingdom.

The law of negligence, as a coherent and principled body of law became established in the UK only in 1932, although the basic concepts and ideas that underlies it, perhaps, pre-dates that[422]. Since then, medical negligence under the English common law has undergone several evolutionary milestones throughout the history of healthcare in UK[423].

From the beginning of the 20th century leading up to the 1980s, doctors' power of control climaxed during the so called golden age. It was during this period that the NHS was founded, the *Bolam* principle[424] was expounded and the doctors' negligence was being viewed as distinct from others'. Also during the period, the patients had much fewer rights in medical negligence. Even with the introduction of privatization to the NHS that raised patients' expectations during the period leading to the 21st century, doctors still maintained power of diagnosis with the self-regulation of medical negligence. The "Bolam" precedent became under increasing pressure in the law courts, which culminated in the "Bolitho"[425] decision which arguably and theoretically gave the judges some latitude of discretion in determining the reasonableness of expert opinion in exceptional cases with little or no practical change from "*Bolam.*"

In 2003, as a part of quality improvement strategy, the department of health introduced the

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422 Christopher Walton, *Charlesworth & Percy on Negligence* (12th ed, Sweet & Maxwell, 2010) paras 1 34

423 Kim Price, *'Towards a History of Medical Negligence'* (2010) 375 The Lancet. Issue 9710, Pages 192 - 193

424 *Bolam v Friern Hospital Management Committee* : (1957) 1 WLR 582

425 *Bolitho v City and Hackney Health Authority* (1997) 4 All ER 771

concept of duty of candour which makes a mandatory requirement of providers to take responsibility of their negligent acts and show remorse to the patients when errors occur during medical treatment. The *NHS Redress Act of 2006* also made recommendations that provided for a 'no fault' system to deviate attention away from blame culture to the one that encourages learning from mistakes.

The Nature of Medical Negligence in UK

Generally, under English law, negligence is a tort or civil wrong that results in a foreseeable harm arising from the breach in a duty of care[426].' It may also arise under any one of the other two realms of law; criminal and contract law. Criminal cases arise from lack of full consent, assault and battery; while contract cases feature where a consideration is advanced in return for the medical services, or where a doctor gives a warranty of specific outcome[427]. Most of the medical negligence claims come under the law of tort where no contractual relationship exists. Such tortuous relationship is captured Lord Atkin in *Donoghue (or McAlister) v Stevenson*[428]

> "The rule that you are to love your neighbour becomes in law , you must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.

The tortuous concept of negligence seeks to serve compensation, correction and deterrence[429].As stated earlier on, medical negligence, although a subset of tort of negligence, could also arise from a breach of contract against a physician or hospital as the two duties are analogous under

426 MA Branthwaite, *'Medical Negligence Yesterday and Today'* (1998) 9 Current Anaesthesia & Critical Car
427 *Ibid*
428 [1932] All ER Rep 1
429 J. Gilmour, Patient Safety, *Medical Error and Tort Law: An International Comparison*, report submitted to Health Canada (2006)

the law of negligence[430].

When negligence is compared with the so-called 'no-fault' system, the former focuses on errors committed by individual healthcare providers, while the latter focuses more on the prevailing 'conditions and systems' as the cause of errors, and develop preventive measures to avert future occurrences[431] .

The tort of negligence depends on the presence of fault or the breach of a standard.' Theoretically, negligence identifies an individual or (his employer) who is responsible in law for the infliction of the patient's injury, and so, in fairness ought to recompense the patient for that loss'

A health care professional's liability in negligence cases could be a criminal liability, if his act/ omission constitute an offense, for example, assault and battery. It may also be disciplinary liability for bringing disrepute to the profession with sanctions ranging from suspension to even exclusion from practice. Compensatory (civil) liability is incurred, if a) the alleged harm caused to the complainant has a causal link with the defendant's breach of an owed duty of care or, b) in cases involving payment for health services, for a breach of contract.

To succeed a claim in medical negligence, the plaintiff must discharge the burden of proof by establishing, on the balance of probability, well established elements of medical negligence, to wit, a duty of care, breach, harm and causation.

A duty of care is the circumstances and relationships that create an obligation on the defendant to take proper care to avert a foreseeable injury to the claimant which can simply be implied once a

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430 I. Kennedy and A. Grubb, *Medical Law*, Butterworths (2000), pp. 271 and 272.

431 F Oyebode, *'Clinical Errors and Medical Negligence'* (2006) 12 Advances in Psychiatric Treatment.221-7 at 222, citing J. Reason, *'Human Errors: Models and Management'*, 320 British Medical Journal (2000)

professional-patient relationship is established[432]. A health care professional is said to assume a duty of care toward that patient once he/she agrees to examine, diagnose or treat a patient or when medical risk recognized[433]. Although a health professional is not obliged to assume a duty of care in circumstances outside of his official work, but where he volunteers to assist, the same standard of care will apply[434]. Furthermore, where a patient consents to an experimental test, the duty of care of a therapeutic standard is not required[435].

If the defendant fails to treat or manage the plaintiff at standard a reasonably competent health care professional would have done in a similar situation, then he/she has breached a duty of care. This was further adumbrated in *Bolam's case* where the court held that;

> …the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is a well-established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art[436].

Additionally, that test must be based on some scientific and technical standards contemporaneous to the negligence, not some *archaic* standard applied in the present day. Although professionals are required to keep up-to-date with current state of practice, they are not expected to read every single journal.

Before the advent of *Bolam*[437], there was considerable latitude for external evaluation of clinical judgment in proof of standard of care in medical negligence cases. The *Bolam* test brought about a significant milestone to the determination of standard of care, wherein, 'determining the standard was seen by the courts as essentially a matter for the medical profession, to be resolved

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432 G. Robertson, *'Negligence and Malpractice', in J. Downie, T. Caulfield and C. Flood (eds), Canadian Health Law and Policy*, LexisNexis (2002), p. 91

433 *Newman & others v United Kingdom Medical Research Council* (1996) CA

434 *Goode v Nash* (1979) 21 SASR 419

435 *Siwa v. Koch* (2009) 1–06–3552 CA. Ill. Feb. 2010.

436 *Bolam v Friern Hospital Management Committee Ibid.*

437 Harvey Teff, '*The Standard of Care in Medical Negligence - Moving on from Bolam?'* (1998) 18 Oxford Journal of Legal Studies pg 103

by expert testimony with minimal court scrutiny.' Contemporaries of this decision alluded to the thought that "excessive judicial interference raises the specter of defensive medicine, with the attendant evils of higher medical costs and wastage of precious medical resources." All that was required by the law was to establish a standard of care was a "reasonable practice by a reasonable practitioner."

Under the *Bolam test*, what constitutes a standard of care was determined by the professionals. Expert testimony helped courts to decide what is accepted and proper practice in specific situations[438]. That is to say, "the law imposes the duty of care: but the standard of care is a matter of medical judgment[439]."

In determining the standard of care, therefore, it is instructive to recollect the *Bolam* principles enunciated by *McNair J.:*

> "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular area... Putting it another way around, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."

The principle in *Bolam* has been criticized for allegedly granting "exceptional prominence to expert evidence of professional practice.[440]" However, in *Hunter v Hanley[441]*, the court reiterated that;

> The true test for establishing negligence on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care …"

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438 B Hurwitz, '*How Does Evidence Based Guidance Influence Determinations of Medical Negligence*?' (2004) 329 BMJ

439 Per Lord Scarman, *Sidaway v. Board of Governors of the Bethlem Royal Hospital*, 95 [1985] AC 871

440 Rachael Mulheron, '*Trumping Bolam: A Critical Legal Analysis of Bolitho's "Gloss"*' (2010) 69 The Cambridge Law Journal 609, 609–638

441 (1955) SC 200, 1955 SLT 231 at 217

The House of Lords in the case of *Bolitho*[442] added a qualification that the courts may make their own assessment of experts' opinion and reach their own conclusions on the reasonableness of a clinical judgment to the effect that standard of practice claimed must be recognized as 'proper by a reasonably competent body of opinion'. That is, any opinion relied upon has a logical basis. The effect of the *Bolitho* standard is that it tended to replace 'inappropriate deference to medical opinion' with rule of law which requires listening to all parties, just like it applies to all other professionals[443].

The Traditional Rule of Bolam Test:

In medical litigation, the central question that arises is whether or not a doctor has attained the standard of care that is required by law. The standard expected is one of reasonable care. This needs to be judged by taking into account all the circumstances surrounding a particular situation, and by balancing the diversity inherent in medical practice against the interests of the patient. An essential component of an action in negligence against a doctor is proof that the doctor failed to provide the required standard of care under the circumstances. Traditionally, the standard of care in law has been determined according to the *Bolam* test. This is based on the principle that a doctor does not breach the legal standard of care, and is therefore not negligent, if the practice is supported by a responsible body of similar professionals.

The case of *Bolam vs. Friern Hospital Management Committee*[444] is an English tort law case that lays down the typical rule for assessing the appropriate standard of reasonable care in negligence cases involving skilled professionals (e.g. doctors). Mr. Bolam was a voluntary patient at Friern Hospital, a mental health institution run by the Friern Hospital Management Committee. He

442 *Bolitho v. City & Hackney Health Authority* [1998] AC 232 , p241

443 M. Brazier and J. Miola, *'Bye-Bye Bolam: A Medical Litigation Revolution', 8 Medical Law Review* (2000): 85-114 at 114

444 [1957] 1 WLR 582

agreed to undergo electro-convulsive therapy (E.C.T.). He was not given any muscle relaxant, and his body was not restrained during the procedure. He reacted violently before the procedure was stopped, and he suffered some serious injuries, including fractures of the acetabula.

He sued the Committee for compensation. He argued that the doctors were negligent for:

a) By not issuing relaxants;

b) By not restraining the patient and

c) By not warning him about the risks involved.

McNair J, (as he then was) at the first instance, noted that expert witnesses had confirmed that many medical opinions were opposed to the use of relaxant drugs and that manual restraints could sometimes increase the risk of fracture. Moreover, it was the common practice of the profession not to warn patients of the risk of treatment (when it is small) (as at that time) unless they are asked. It was held that what was common practice in a particular profession was highly relevant to the standard of care required. He said further that a doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.

The Bolam Application

The *Bolam* test was applied in different other cases by the House of Lords such as in ***Maynard v West Midlands RHA***[445]. The claimant here was being treated for a chest complaint. Her consultant believed she could have *tuberculosis,* but decided to carry out an exploratory diagnosis given the slight chance of *Hodgkins* disease. The diagnosis confirmed the *tuberculosis*,

[445] [1984] 1 WLR 634, HL

but unfortunately left the claimant paralyzed in one of her vocal cords due to an inherent risk without any fault on the defendant's part.

At trial, the medical expert witnesses were divided as to the necessity of the diagnosis, upon which it was concluded that the risks of the diagnosis was not worth taking, and awarded damages against the defendant.

On appeal, the House of Lords, per Lord Scarman stated that

> *A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not (just) enough to show that there is a body of competent professional opinion which considered that theirs was a wrong decision, if there exist a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken, it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.*

It is easier for the courts to chant the principle in *Bolam* repeatedly and yet another issue for it to be applied in practice. Practically, the courts have applied a different standard to cases outside the context of medical negligent.

Thus irrespective of the repeated statement of the court in *Bolam* that the test to be applied in medical negligence is the test of the ordinary skilled man exercising and professing to have that special skill, and that a man is not negligent. It becomes pertinent then, that in order to reach a reasoned decision, the opinions of experts in the field of dispute would have to be considered. In the case of *Associated Provincial Picture Houses Ltd v Wednesbury Corporation*[446], Lord Green restated that Judges would always resort to expert medical opinion mindful of their own lack of medical knowledge unless the opinion of a doctor or group of doctors was unreasonable.

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446 [1948] 1 KB 223 CA

In *Bolitho (Administratrix of the Estate of Patrick Nigel Bolitho) v City and Hackney Health Authority*[447] Lord Browne-Wilkinson reechoed the submission of Mr Brennan regarding the *Bolam* case that the Judge had wrongly treated the *Bolam test* as requiring him to accept the views of one truthful body of expert professional advice even though he was un-persuaded of its logical force. He submitted that the Judge was wrong in law in adopting that approach and that ultimately it was for the court, not for medical opinion, to decide what was the standard of care required of a professional in the circumstances of each particular case.

Criticisms of the Bolam Test.

The main issue about *Bolams principles* is that it has paid much attention to what has been done whether good or bad instead of what should be done rightly. The *Bolam* test would not deny that an action is negligent as long as it is in conformity with the professional and responsible opinion of body of medical men. It does not want to know whether the action the medical man had taken is of a reasonable standard of care expected of a man of that class. But it is more concerned about its conformity with the Body of medical opinion. The principles of *Bolam* tend to say that what ought to be done should be changed to what is done regardless of the standard of what is done, whether the practitioner is negligent or not, weighing all the circumstances surrounding the case. The principles have made the medical practitioners to carve out for themselves the standard of care they would adopt whether it is in the positive or in the negative. One wonders whether this should be the case since in other professions it is the court that determines what standard of care that professions should adopt. The medical profession has been the only profession that has adopted this standard of care. From the time immemorial, in *Stratton vs. Swanland*[448] and

447 [1997] 3 WLR 1151
448 (1374) 7 KB

Pollard[449] *vs. Dr. Cooper*, with the emergence of Bolitho's decision, an awareness has been created on individual patients' rights on medical intervention about surgical or medical negligence. This is about ethical issues of any profession and fundamental rights of individual patients. People have consistently criticised the Bolam test and would rather prefer that the court should set the standard, of the profession instead of letting the profession set its own standard. Lord Bridge (as he then was) in the Sideway case, where a case concerning the level of information disclosure to a patient, the justice said that a breach of duty of care is an issue that should be that primarily decided using the expertise of the professional Body of medical men. This is because he believed in the Bolam's principles.

Sudden Shift from the Traditional Rule of Bolam Test

Patrick Bolitho was an interesting case that helped to counter the harsh principles of Bolam. It was a case that dragged up to the house of Lords for the resolution. The case- Patrick was 2 years old when he had a brain damage which he sustained from cardiac arrest and respiratory failure. In his case *Bolitho vs. City & Hackney Health Authority*[450], where he was admitted. His father Bolitho felt they were negligent on his treatment. The report was that the paediatric registrar did not see him to treat him. The female registrar had claimed that even if she had seen him, there wouldn't have been any difference and held that she was not negligent at all. Her response to this allegation was so negative and was even supported by so-called responsible Body of medical men.

But in the court, led by Lord Brown-Wilkinson (as he then was), had a different opinion from the Body of medical men. He said he had to be satisfied that the Body of medical men or professional Body of responsible, reasonable and respectable men's opinion that would be relied

449 (1765)9 KB
450 (1997) 4 ALL ER 771

upon would be a considerable one. The Judge maintained that he has to take note of the necessary risks involved, weigh them against the benefits that should equally be involved. The court said it cannot pigheadedly accept the views just like that because it has come from the expert opinions of body of professional men of high repute. The court went further to say that before they could accept these views of medical men; it must have to put everything on the weighing scale to establish actually the truth of the matter.

This case from the highest court in the land, was able to counteract the effect of Bolam which stuck its judgments based on the Bolam's principles. It maintained that every case has to be assessed on its own merit and not to base it on the merit of professional Body of respectable, responsible Body of medical men. The court also said it has to have a holistic approach to all the issues in contention, basing everything on the validity of each issue. A summary of discussion in Bolam and Bolitho cases regarding surgical and all medical negligence cases, the summary, is while in Bolam principle/test, the standard of care of the medical men was based on the principle of Bolam which is that, once the decision taken by the medical man is in support of the Body of professional, respectable and responsible medical men, who had held that opinion as right, there will be no problem. But not Bolitho's, the court has held the opinion that before an acceptance is made to the claim of the medical man, it has to weigh all the circumstances surrounding each case, the cost-effectiveness, the risks involved and the severity of the damages. The court would have a holistic view on every issue concerned before it makes a decision on the particular case. As it is now, people are satisfied that it would be no longer all Bolam's defensiveness but now would be Bolitho's justifiable case.

A Brief Analysis of Bolam and Bolitho's Decisions

In medical litigation, the test for the standard of care in law expected of doctors is based on the principle enunciated in *Bolam*. Put at its simplest, the test is that a medical practitioner does not fail to reach the standard of care if a responsible body of similar medical peers supports the action in question. The judgment in Bolitho, however, suggests a judicial move at the highest level to shift the balance from an excessive reliance on medical testimony supporting a defendant doctor, to a more enquiring approach to be taken by the court. In order to reach its own conclusion on the reasonableness of clinical conduct, the court will arbitrate on the standard in each case. This would operate within the framework of normative values held by society. Patient empowerment is a strong theme in the new health service. This is likely to act as a conjunctive force in shifting the traditional accepted practice approach to one whereby the standard of care is set by the court on the basis of expected practice. This would be determined by evaluating the reasonableness of competing options.

In practical terms, the court would scrutinize more intensely the basis on which defendant doctors proclaim the standard of care. There would be a requirement to justify this on a logical basis. The court would look for logical analysis, and the opinion expressed would have to be coherent, reasoned and evidence based.

The court would also apply a risk analysis approach by seeking justification of the medical decision taken against competing alternatives. The emergence of independent guidance on good practice would enable the court to utilise the Bolitho principle more proactively in setting the expected standard of care required of doctors, in cases of medical litigation. In other words, it may no longer be sufficient for a practitioner's actions to be *Bolam*-defensible. The court would seek to determine whether such action is Bolitho-justifiable.

The rejection of *Bolam* does not however mean that there is no role for expert medical evidence in medical negligence hearings. The evidence is necessary to show what the ordinary practice in the field is so that the court can assess whether, as a matter of law, the defendant doctor has complied with the standard required of a reasonable person practising in the field. The fact that a defendant doctor has complied with ordinary practice will not determine the matter, for the court has the right and obligation to determine, in each case, what is the requisite standard of care. However, the court should be slow to intervene to substitute its judgment for the clinical expertise of a treating doctor when it can be shown that the decision in the particular case accorded with the ordinary practice.

The mere fact that there are two alternative treatments available will not establish negligence where the defendant has chosen or recommended one treatment over another. Also, a court will not, by mere preference of one view over another, find that the doctor was negligent for making a choice that the court, in retrospect, would not have chosen. There must be more than a mere preference before a court will find that a choice between competing views was wrong and negligent. Nonetheless, Bolitho has been hailed as ushering in the new Bolam.

Reliefs for a Successful Claim.

In the case of physical injury, it is impossible to restitute the plaintiff in status quo ante prior to the negligent act. However, present or future financial losses consequential to the injury may be compensated[451]. A successful litigant is entitled to damages to compensate for the injury or loss which may be economic damages where monetary compensation is awarded to cover, for instance, cost of treatment, or non-economic damages, for example, for pains and sufferings[452].

Where an actual injury could not be proved, damages may still be awarded for loss of chance of

[451] Robert Palmer and Mary Maclachlan, *'Clinical Negligence'* (2009) 10 Anaesthesia & Intensive Care Medicine

[452] Laura Stanila, *Medical Liability for Malpractice 2005 Studia Iuridica Auctoritate Universitatis Pecs 143*

better outcome[453]. Such damages will generally be less than those awarded under causation[454]. In England, the National Health Service (NHS) mainly employs healthcare professionals. Under the doctrine of vicarious liability the employer is liable for medical liability expenses or claims incurred by its employees during the course of their employment, and therefore, medical liability insurance is unnecessary[455]

5.2 Tortuous Liabilities of Medical Practitioners in *Saudi Arabia.*

Saudi Arabia is a culturally conservative Islamic society whose legal system is rooted on the *Sharia* which offers guidance for mankind in matters pertaining to their worldly and spiritual affairs[456]. The *Saudi Sharia* law is in general, applied in a more conservative and strict manner than other countries within the Middle East[457].The primary sources of *Shariah* are *the Qur'an* and the *Sunnah*, which together define the legal, moral and ethical duties, rights and relationships between humans. For instance, the Holy *Qur'an* spelt out the law of retaliation as thus;

> 'And we ordained therein for them: Life for life, eye for eye, nose for nose, ear for ear, tooth for tooth and wounds equal for equal. But if anyone remits the retaliation by way of charity, it shall be for him expiation[458].

The *Sunnah*, as a primary source, has provided for a number of issues what were not explicitly provided for by the *Qur'an*. For example, the saying of the *Prophet Muhammad* (peace be upon him) regarding the legal capacity of the insane, child or a person in a sleep:

> The pen has been lifted from three: the sleeper until he awakens, the child until his first

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453 *Rufo v. Hosking* (2002) NSWSC 1041, 246

454 Tibballs, J. (2007). *Loss of chance: A new development in medical negligence law. Medical Journal of Australia*, 187(4), 233-5

455 *The Catholic Child Welfare Society & ors v Various claimants & The Institute of the Brothers of the Christian Schools* [2012] UKSC 56

456 Puteri Nemie Jahn Kassim, '*Medical Negligence in Islamic Law' (2006) 20 Arab Law Quarterly, 400–410.*

457 Wayne Jones, *Shabnam Karim and Louise McDonald, 'An Overview of Medical Malpractice in the Kingdom of Saudi Arabia' (Clyde & Co)*

458 *Holy Qur'an 5:45*

wet dream, and the insane person until he can reason[459].

Where an issue is not directly dealt with by the primary sources, scholars may employ a secondary source, *ijtihad*, the law of deductive logic[460], to interpret and contextualize religious teachings[461]. The contemporary advances in science and technology have added to the range of novel issues that have created medico-legal dilemmas for those involved with healthcare delivery[462].

Professional ethics also play an integral part of medical negligence rules. The Islamic medical ethics[463] was founded on the principles of human honor, right to live (human life is respected and protected), and equity ("deal not unjustly and you shall not be dealt with unjustly"). Others include, doing well (quality), and "no harm and no causing harm (do no more harm)."

Saudi Arabia is, like most other conservative Muslim world, is a culturally sensitive society. Therefore, healthcare professional must have some basic knowledge of its *sharia* driven culture to enable them deliver care effectively[464]. This could also enable healthcare professionals to appreciate of the moral contexts used by the patients to possible initiate medical negligence claims.

Healthcare Professional's Civil Liability under the Shariah.

The Islamic concept of civil liability is neither "fault liability", nor "strict liability", but may be described as "damage liability." It is based upon the principle of indemnity against actual

459 Kelle NHM. *Reliance of the traveller. Maryland: Amana*, 1994:42–6

460 A Gatrad, '*Medical Ethics and Islam: Principles and Practice'* (2001) 84 Archives of Disease in Childhood 72, 72–75.p73

461 *Ibid*

462 *Ibid*

463 World Health Organisation, 'Islamic Code of Medical and Health Ethics', Regional Committee for the Eastern Mediterranean (2005)

464 A Gatrad, '*Medical Ethics and Islam: Principles and Practice' (2001)* 84 Archives of Disease in Childhood 72, 72–75.

damage; "no liability without damage[465]."

Medical negligence liability may arise from a breach of contractual agreement between the professional and the patient, or from the provision of the *shariah law*[466].

Ordinarily, a qualified doctor who performs his duties correctly, and does not contravene with the *Shariah* principle will not be liable for any mishap which is beyond his control. On the other hand, an unqualified professional who causes injury to a patient shall be liable unless the patient is aware of his non qualification, and agrees to the treatment despite that. Similarly, a treatment without the consent of the patient or his relative can incur civil liability for any injury caused. Where a professional uses or tries a new machine or technique to treat a patient, he will be liable in medical negligence unless that has been endorsed by the government[467].

Proof of Medical Negligence under the *Shariah*

The following conditions are required to prove medical negligence:

1. **Breach of Duty *(al ta'addi):***

As has been pointed out earlier on, the duty might arise from contractual relationship or from the operation of the law. A professional may breach a duty either directly (by an act of commission) like amputating the sound leg, or indirectly by an act of omission like failure to perform a treatment required which resulted in injury or deterioration in his condition[468]. However, the professional may raise a defense of consent or that it was done in an emergency to save life.

2. **Damage/Injury *(al-Darar):***

The claimant must show that the defendant's wrongful act has caused either a physical (to the

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465 Muslehuddin, M., *Concept of Civil Liability in Islam and the Law of Torts, Islamic Publications Ltd., Lahore,* 1982 at p. 53

466 *Al-Ghamid, Masculiyyah al-Tabib al-Mihaniyyah, Jeddah: Dar al-Andalus, 1997, at p. 219*

467 *Ibn Qayyim, Z?d al-Mac?d, Beirut: Maktabah al-Manr, 1407H, Vol. 4, at p. 141*

468 *Al-Khatabi, Maclim al-Sunan, Cairo: Matbacah Ansar al-Sunnah, 1367h, Vol. 6, at p. 378*

body) or moral injury (to honour or reputation, as in a breach of confidentiality) to him[469]. Usually, physical harm entails blood money.

3. **Relationship *(al Ifdha):***

There has to be a direct causal relationship between the breach of duty and the harm caused. A causal relationship may be direct *(al mubasharatah*)[470] or indirect (*at tasabbub*)[471] such as where a doctor made a wrong prescription which made a pharmacist to dispense a wrong medication, or a nurse to prepare a wrong medication and ultimately killing the patient[472].

Standard of Proof of Medical Negligence under the *Shariah.*

If you plan to make a claim in medical negligence, the Qur'an reckons on you to "bring forth your argument if you are telling the truth[473]. In order to substantiate the allegation, evidence has to be adduced by way of admissions, documents, or expert evidence.

Admission *(al-Iqrar):*

Where a professional of sound mind freely admits guilt in the presence of many witnesses, it may be a sufficient proof of liability in negligence.

Witness *(al-Shah'dah):*

The Qur'an says "and take for witness two persons among you, endued with justice, and establish the evidence (as) before *Allah*"[474] If there are witnesses to the wrongful conduct of the doctor, the doctor will be liable[475], provided that the statement given by the witnesses must be verified by other doctors, specializing in the same field, to confirm that what the doctor did not

469 *Ibid* No. 159, at p. 193.
470 *Ibid* No. 159 p196
471 *Ibid* No. 159 p197
472 *Jawziyyah, al-Tibb al-JVabawi, Beirut: Dar Maktabah al-Hay?h, 1407H, at p. 137.*
473 *The Holy Qur'an, 27: 64*
474 *The Holy Qur'an, 65: 2*
475 *Ibid* No. 159 p. 281

accord with accepted medical practice[476].

Opinions of specialists *(Ra'yu al-Khab'r):*

The opinions of other doctors, specializing in the same field, is also important to determine a doctor's liability. Even one opinion may be sufficient to show that the doctor is liable[477].

Written documents *(al-Kit'bah);*

Documentary evidence of contract or medical records may be useful under the Islamic law of evidence. The Holy Qur'an says: "When you deal with each other, in transactions involving future obligations in a fixed period of time, reduce them to writing[478]".

Reliefs Available under the *Shariah* Law of Medical Negligence

Under the Islamic law, the infliction of harm, whether deliberate or by negligence, gives rise to compensation. The Holy Qur'an say "If then anyone transgresses, the prohibition against you, transgress you likewise against him.[479]"

Usually, blood-money *(Diyah)* is the monetary compensation imposed on the accused for causing homicide or bodily injury.

> Never should a believer kill a believer, but (if it so happens) by mistake (compensation is due); if one so kills a believer, it is ordained that he should free a slave and pay compensation to the deceased family, unless they remit it freely[480].

The *Saudi Arabian* Law of Practicing Healthcare Professions

Unlike under the English legal system, the Saudi Arabian legal system is based on the principles of *Shariah* , which, as stated earlier, is primarily sourced from the *Qur'an* and the *Sunnah*(deeds)

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476 *Ibid* No. 159 p. 282
477 *Ibid* No. 159 p. 283
478 *The Holy Qur'an, 2: 282.*
479 *The Holy Quran 2:194*
480 *The Holy Qur'an, 4: 92.*

of Prophet Mohammed.

The Monarch (King) is responsible for legislation by way of royal decrees according to the *Shariah*[481]. The royal decrees may empower ministers to make, by ministerial resolution, subsidiary laws and regulations to deal with specific areas or issues within the purview of their ministries[482].

In the light of the above, the royal decree vested[483] the ministry of health with the power to issue The Law of Practicing Healthcare Professions that governs medical negligence in Saudi Arabia. It is comprised of the regulation based on professional standards, as well as the procedures for its implementation based on the *Shariah* law principles. The Law was passed by the ministerial resolution number 276 of 3/11/1426 (H)[484].

Professional standard dictates the culpability of the healthcare professionals, while the *Shariah* law determines the reliefs available to the successful party in cases involving personal (similar to civil) rights, and/or punishment incurred by the defendants if common (public) right(s) is/are involved. The *Sharia's* personal right relief is usually 'compensation for any disability, morbidity or mortality that results from proven negligence or malpractice of medical intervention.' Punishment for public right may be 'criminal' or 'disciplinary' in form which includes one or a combination of fine, imprisonment, lashes, revocation of licensure or some other restrictions[485].

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481 *Article 1, Basic Law of \Governance, Royal Decree no.A90 of 27/08/1412 (1/3/1992)*

482 *Article 67, Basic Law of \Governance, Royal Decree no A90 of 27/08/1412 (1/3/1992)*

483 *Decree no. M/59 of 4.11.1426 (H)*

484 Law of Practicing Healthcare Professions (previously, Rules of Implementation of The Regulations for the Practice of Medicine and Dentistry, 1401

485 *Articles 26, 28 & 31 of The Law*

Duties and Obligations of Practicing Healthcare Professionals

Chapter two of the Law, which comprises of *Articles 5 to 25*[486], stipulates the professional's responsibilities generally, that is, his obligations to his patient as well as to his colleagues. A failure on his part to discharge any of these responsibilities may be a valid ground for one or combinations of legal liabilities stipulated under part three (3).

The duties incumbent on healthcare professionals are further categorized in to general (public) duties[487], obligations towards the patient (civil)[488], and professional courtesy. It requires that practicing healthcare professionals should "exert due care in line with commonly established professional standards" in discharging their duties[489].

The healthcare practitioner may, in a non-emergency situation, refrain from treating a patient for personal or professional reasons if that would jeopardize the quality of care he provides to the patient, on condition that this [refrain] does not harm the patient's health, and that there is available another practitioner who is capable of treating the patient instead of him/her[490].

Liability of Practicing Healthcare Professionals.

The Law identified and categorized three basic types of liabilities that a practicing healthcare professional may incur in breach of the various duties stipulated under the Law. The liabilities are classified according to the type of duty that was breached by the professional.

A professional liability under the Law may be a civil liability where a physician fails in his responsibility to a patient with a resultant harm to that patient (Articles 26 and 27). Grounds for Civil Liability include error in treatment, lack of follow-up, or deficiency in knowledge of

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486 Law of Practicing Healthcare Professions (previously, Rules of Implementation of The Regulations for the Practice of Medicine and Dentistry)

487 *Articles 5-14*

488 *Articles 15-23*

489 *Articles 24-25*

490 *Article 16*

technical matters which are ordinarily known to his colleagues of similar specialty. Others include conducting unapproved experiments or scientific research on a patient. Similarly, prescribing medicine to a patient on an experimentation basis, or using medical devices or equipment without proper knowledge of mode of its operation or without taking precautions to prevent harm to the patient. A failure to consult relevant colleagues when patient's condition warrants is also a valid ground for civil liabilities[491].

Penalties for civil liability include payment of fine as indemnity, the amount of which is to be determined by the *Shariah* Medical Panel. Even where harm has not resulted to a patient, a healthcare professional's failure in his general obligations may incur a criminal liability. This is usually for his failure to abide by the specific provisions of the Law, including practice without license, obtaining license through illegal method or giving distorted information or to profess as a practicing healthcare professional even though one is not licensed[492].

5.3 Tortious Liabilities of Medical Practitioners in South Africa.

Medical malpractice is a cause of action found in law and occurs when there is a deviation from the set standards of practice by a medical or healthcare professional, which subsequently causes harm or injury to the patient. The medical or healthcare professional is therefore held liable for such harm. In common law, medical malpractice liability is based on the law of negligence and must be grounded in contract. Medical malpractice cannot be assumed to have occurred, and therefore in order to prove liability, certain criteria need to be met. The accuser must show:

a) there existed a legal duty
b) there was a breach of such duty
c) injury must have been caused by the breach and
d) the breach must have resulted in damages.

491 Article 27 *Ibid*
492 Article 2 *Ibid*

In addition, medical malpractice liability may be incurred in cases where there is alleged assault as a result of lack of informed consent[493], invasion of privacy due to disclosure of a patient's medical information without consent, performance of a procedure that is deemed unnecessary, and when medical service providers fail to perform an agreed-upon service resulting in a breach of contract[494].

Medical malpractice requires a deviation from set standards of practice and consequently, the deviation results in a medical error. Such an error could be any of the following:

i. Surgical errors, unnecessary surgery or surgical procedures at the wrong site on the body;

ii. Prescribing improper medication or prescribing the wrong dosage;

iii. Mistreating/ignoring laboratory results;

iv. *Misdiagnosis* or failure to diagnose a medical condition;

v. Premature discharge of a patient;

vi. Poor follow-up/aftercare of a patient[495].

Medical procedures involve medical treatments or operations. Medical procedures are inherently risky in nature as many medical treatments have side-effects and operations involve necessary incisions into the human body[496]. A medical professional is, therefore not liable for all the harm experienced by a patient[497]. They are, however legally responsible for any pain or injury suffered by a patient as a result of deviating from the practices normally expected for quality healthcare.

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493 Informed consent is a more comprehensive form of consent in that it requires permission to be granted with the full knowledge of any possible risks, benefits and consequences

494 Oosthuizen W T and Carstens, P A, "*Medical Malpractice: The Extent, Consequences And Causes Of The Problem"*, (78) *THRHR*, pp 269-284, 2015.

495 In *M M v Dr S Vallabh* this standard of practice was discussed with regard to improper after discharge care and general handling of the patient whose surgery wound subsequently became necrotic and required extensive debridement. Available from: http://www.saflii.org.za/za/cases/ZAGPJHC/2017/397.pdf Accessed 4th March, 2023

496 Brazier, Y, "All about side effects", Medical News Today, 31 March 2017. Available from: https://www.medicalnewstoday.com/articles/196135 Accessed 4th March, 2023.

497 Pandit, M S, Pandit, S, "Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defense - A legal perspective", Indian Journal of Urology, vol. 25, issue 3, page 372 – 378, 2009..Available from: http://www.indianjurol.com/article.asp?issn=0970 1591;year=2009;volume=25;issue=3;spage=372;epage=378;aulast=Pandit , Accessed 4th March, 2023.

Damage or injury to a patient can take on the form of pain and suffering, loss/limitation of a body function or enduring hardship, *disfigurement,* loss of income, and disability[498]. Where a patient is dissatisfied with the outcome of treatment received, they cannot imply that there was medical malpractice involved as there would be no resultant harm or injury from the medical treatment received. In cases where the medical professional is found guilty of medical malpractice, the patient will be awarded damages for the injury suffered. The damages can either be compensatory in nature for the economic and functional loss suffered, or punitive in nature if the medical professional is found to have acted maliciously or with willful misconduct[499].

The highest medical malpractice settlement in South Africa was settled out of court in the amount of R25 million[500]. A neurosurgeon was found to be liable for the brain damage suffered by an 11-year old girl after numerous brain surgeries performed by Dr *Minette du Preez.* The patient had been born with a brain bleed which required a shunt to be inserted at the age of five to drain excess fluid from the brain. In 2009, Dr *du Preez* advised the patient's parents that a new shunt would need to be inserted to relieve the patient's headaches. The operation that followed was unsuccessful and necessitated a further three operations to attempt to place the shunt in the correct position. During investigations, it was discovered that the first two operations had caused brain damage to the patient. The claim was settled out of court.

The test for medical negligence differs from that of negligence in delictual claims. In the case of *Mitchell v Dixon*[501] it was stated that "a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to

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498 Neethling, J et al, *Law of Delict*, LexisNexis, 7th Edition, 2015, pages 221 – 226

499 *Ibid*

500 "R25m awarded in medical malpractice suit", news24, 2013.. Available from: https://www.news24.com/southafrica/news/r25m-awarded-in-medical-malpractice-suit-20130616 Accessed 4th March, 2023

501 *Mitchell v Dixon* 1914 AD 519 at 525

employ reasonable skill and care; and he is liable for the consequences if he does not. Medical negligence liability can also be incurred by a 'failure to act' by a medical professional. The standard by which negligence is measured is that of the "reasonable man" test, which is then applied to medical practice as a reasonable medical professional in a similar situation.

In the case of *H N v MEC for Health, KZN*, the defendant's employees were found to have been negligent by virtue of a 'failure to act' in that they failed to monitor the heart rate of the *foetus* every half hour. The necessary *C-section* was also not performed timeously, resulting in *foetal* distress that in turn resulted in the baby being born with cerebral palsy.

A classic test for negligence was set out in *Kruger v Coetzee*[502], where the court stated that liability for negligence arises if a reasonable person, in the position of the defendant, would foresee the reasonable possibility of his conduct injuring another person and take reasonable steps to prevent such occurrence, which he failed to do.

Medical malpractice versus medical negligence in South Africa

Medical malpractice can be defined as medical treatment provided by a medical professional who is deemed to be below the acceptable standard of care expected from a medical professional[503]. Medical negligence has an element of omission or 'failure to act'. However, it is important to note that not every undesirable outcome in medical practice can be deemed to be medical malpractice as medical professionals can only do so much in any given situation[504]. In some instances, they may not be able to prevent an undesirable outcome or to save a patient's

502 *Kruger v Coetzee* 1966 (2) SA 428 (A)

503 Meyer, E.C, *An Analysis of the Duty of Care Concept from a Pragmatic Medical Malpractice Perspective* (unpublished Medical Law and Ethics thesis, University of Pretoria, 2017).

504 Steinhausen, S et al, " Short- and long-term subjective medical treatment outcome of trauma surgery patients: the importance of physician empathy", Dove Press, 18 September 2014.: https://www.dovepress.com/short--and-long-term-subjective-medical-treatment outcome-oftrauma-su peer-reviewed-fulltext-article-PPA# Accessed 4th March, 2023.

life. Medical malpractice has an element of intent as opposed to medical negligence which lacks intent. An example of medical malpractice would be a surgeon performing an operation they are not adequately qualified to perform[505]. Although the act of performing the surgery was not intended to be harmful or cause harm, it has an element of intent in that he/she would have known that performing a procedure he is not adequately qualified to perform carried with it a risk that may result in harm. On the other hand, medical negligence applies where a mistake or omission occurs during the process of treating a patient which results in harm. The error or failure could be leaving a surgical object inside a patient[506]. The medical professional in that instance would not have had the intention to cause harm nor had the knowledge that the act would result in harm since the action would have been committed negligently. Where a patient then wishes to pursue legal action as a result of adverse consequences from medical treatment, an attorney would need to evaluate the facts of each case individually in order to determine whether to proceed based on medical malpractice or medical negligence.

Medical malpractice and medical negligence are often used interchangeably in discussions and in some claims processes as the critical elements for incurring lability are essentially the same. However, the critical difference lies in the medical professional's 'intent' while carrying out the medical treatment in question. The intent factor would call into question whether the medical professional had performed a procedure outside of his/her scope of practice or training, or whether factors such as lack of adequate resources and deviation from normal, expected standards of practice had played a role.

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505 *Ibid*

506 In *Daleen Els v MEC*: Available from: http://www.saflii.org/za/cases/ZANCHC/2017/7.pdf Acessed 4th March, 2023.

Liability for Medical Malpractice and Medical Negligence in South Africa.

In a successful claim against the actions or lack thereof of a medical professional, the claimant is awarded damages for the injury suffered. South Africa does not have a specific law that deals with medical malpractice and medical negligence claims[507]. The common law is utilised to prove damages and liability in such claims. Where a medical professional is found to be liable for the damages suffered, he or she will be personally responsible for the compensation due to the claimant.

In cases where the medical professional was employed by an organization when the treatment occurred, the employer will be liable to pay compensation to the claimant[508]. Employer liability for an employee's actions or lack thereof is made possible by the doctrine of vicarious liability. For vicarious liability to be invoked, three requirements need to be fulfilled:

i. there must exist an employment relationship,

ii. there must be commission of a delict, which is a violation of the law, and

iii. the delict must have been committed during the course and scope of employment[509].

The question of what circumstances constitute course and scope of employment has been the subject of discussion and scrutiny in many a common law country[510]. In the United Kingdom and other commonwealth countries like Australia and Canada, which have similar legal systems to

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507 Van Dokkum, N, *"The Evolution of Medical Malpractice Law in South Africa*", Journal of African Law, vol. 41, no. 2, pages 175 -191, 1997

508 McQuoid-Mason, D, *"Establishing liability for harm caused to patients in a resource-deficient environment"*, SAMJ, vol. 100, n. 9, September 2010.. Available from: http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742010000900013 Accessed 4th March, 2023.

509 *Mkize v Martens 1914 AD 382 390*

510 Millard, D, Bascerano, E G, "Employers' Statutory Vicarious Liability in Terms of the Protection of Personal Information Act", PER/PELJ 201 http://www.saflii.org/za/journals/PER/2016/12.html Accessed 4th March, 2023.

South Africa, the courts have departed from a strict interpretation of what constitutes a scope of employment. In doing so, they have applied the 'close connection' test[511].

The close connection test questions whether the relationship between the defendant and person who commits a wrongful act or infringement can rise to the occasion of vicarious liability, and whether the wrongful act or infringement is closely linked to such a relationship as to make it just and fair to hold the defendant liable.

In *Lister and Others (AP) v Hesley Hall Limited*[512], the question raised was,

> Whether as a matter of legal principle the employers of the warden of a school boarding house, who sexually abused boys in his care, may depending on the particular circumstances be vicariously liable for the torts of their employee.

It was held that the school was vicariously liable for the warden's assaults and that the employer could be held liable where "the unauthorised acts of the employee are so connected with acts which the employer has authorised that they may properly be regarded as being within the scope of his employment.[513]" The application of the close connection test has been followed by South African law in the highest court in the land. In the *N K v Minister of Safety and Security*[514] case, the Constitutional Court adopted the close connection test to be in line with constitutional values, of which the right to health is enshrined as a fundamental right. The N K case involved a woman who was stranded in the early hours of the morning without transportation. She was attempting to get her mother to pick her up when three policemen in a marked vehicle, full uniform and on duty at the time offered to drive her home. She accepted and, on the way home, the policemen

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511 *Lister and Others (AP) v Hesley Hall [2001] UKHL 22 para 25*
512 *Ibid*
513 *Lister and Others (AP) v Hesley Hall* [2001] UKHL 22 para 25
514 *N K v Minister of Safety and Security* 2005 26 ILJ 1205 CC

took a wrong turn, and all three of them raped her. She subsequently sued the Minister of Safety and Security for damages. The case was dismissed in both the High Court and Supreme Court of Appeal. When the matter was before the Constitutional Court for adjudication, it was held that sufficient neglect of duty as a result of deviation from authorised duties could in certain circumstances be regarded as closely connected to employment[515].

Personal injury claims generate a lot of revenue for attorneys in practice. When the Road Accident Fund introduced strict guidelines for compensation due to personal injury[516], it was inevitable that personal injury attorneys would seek another avenue for making money through a personal injury. Personal injury attorneys have thus been delving more frequently into medical malpractice and medical negligence claims. This has resulted in a steady increase in complaints against medical professionals and medical institutions. Personal injury claims arising as a result of medical treatment have generally favoured medical negligence as a cause of action since there is typically no ill 'intent' when a healthcare worker treats a patient. This approach is regarded as more favourable and easier to prove as most incidents that occur during medical treatment are as a result of negligence or a failure to perform an action. Medical professionals do not, as a rule, set out to intentionally cause harm to a patient[517]. The element of general, specific and constructive intent would, therefore, occur less frequently than omission and would be harder to prove in a court of law.

The medical negligence approach, though generally favoured, is by no means easy to prove or a foregone conclusion in incidents where medical treatment has resulted in adverse outcomes[518].

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515 *Ibid* Paragraph *56 of the judgment*.

516 *The Road Accident Fund Amendment Act 19 of 2005.*

517 Klaas, P B, et al, "When Patients Are Harmed, But Are Not Wronged: Ethics, Law, and History", Mayo Clinic, September 2014.. https://www.mayoclinicproceedings.org/article/S0025-6196(14)00434-0/pdf Accessed 4th March, 2023.

518 *MEC for Health, Western Cape v Q* (928/2017) [2018] ZASCA 132 (28 September 2018).

In this matter the MEC for health appealed a judgment which had found that the medical professionals acted negligently in the treatment of the then pregnant patient resulting in the child being born with brain damage. It was held that the cause of the damage as well as the timing could not be identified.

In the matter of *Goliath v MEC, Eastern Cape*[519], a medical negligence claim was unsuccessful. The case involved a plaintiff who alleged medical negligence by the medical professionals involved in her routine hysterectomy. The surgical wound was closed without removing all the surgical swabs from her abdomen. The plaintiff subsequently suffered from complications caused by sepsis in the wound and abdomen. The surgical swab was consequently later surgically removed. The basis of the plaintiff's claim was that medical staff failed in their duty of care by negligently allowing the wound to be closed before all swabs were removed. It was held that there was nothing before the judge "relevant to what occurred in the operating theatre or of the circumstances surrounding the alleged negligence whatsoever[520]." The plaintiff's claim was dismissed as they failed to show enough factual evidence to prove negligence and therefore satisfy the negligence test. It was also found that the principle of *res ipsa loquitur* did not apply to the case. The *res ipsa loquitur* principle states that the mere occurrence of certain kinds of accidents would be enough to imply negligence[521]. The judgment, in this case, was the opposite of the successes of the *N H v MEC* for Health, *KZN and Lushaba v MEC for Health*, *Gauteng* cases where the medical professionals were found to have acted negligently and therefore were liable for any damages suffered due to a causal link and failure to act being established.

A true and specific reflection of the costs of medical malpractice and medical negligence claims against the private medical sector is not known as most of these claims are settled out of court,

519 *Goliath v MEC for Health in the Province of Eastern Cape* (1084/2012) [2013] ZAECGHC 72

520 *Ibid*. Paragraph 110 o the Judgment.

521 Patel, B, "Medical negligence and res ipsa loquitur in South Africa", SAJBL, vol. 1, no. 2, December 2008.

while claims against medical professionals employed by the Department of Health cite the relevant provincial Department of Health as a defendant or one of the defendants. The implication of this action is that if the claim is successful, the Department of Health of that province becomes liable to the outright payment of the judgment amount. The Department of Health or state is liable in terms of the State Liability Act[522], as amended by the State Liability Amendment Act[523]. The State Liability Act aimed to consolidate law that related to State liability with regard to actions of its employees. Section 1 of the State Liability Act states that any claim instituted in a court of law against the State:

> Shall be cognizable by such court, whether the claim arises out of any contract lawfully entered into on behalf of the State or out of any wrong committed by any servant of the State acting in his capacity and within the scope of his authority as such servant[524].

The State Liability Amendment Act amended section 2 of the State Liability Act by substituting the word "may" with "must" when stating that in proceedings against the State in terms of *section 1*, the Minister concerned must be cited in initiation documents as a nominal defendant. The State Liability Amendment Act also amended *section* 4 of the State Liability Act with regard to liability and provision of specified periods by now stipulating that an order against the State must be satisfied with thirty days of such order or satisfied within a time frame as agreed by the "judgment creditor and the accounting officer" of the department in question.

Liability of Medical Negligence in South Africa.

A breach of a duty of care has negative consequences for both the patient and medical professional. Where an allegation of medical malpractice or medical negligence has been alleged

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522 *State Liability Act 20 of 1957*

523 *State Liability Amendment Act 14 of 2011.*

524 *State Liability Amendment Act 14 of 2011.*

against a medical professional, a disciplinary inquiry may be initiated in terms of the Health Professions Act. If the inquiry results in findings against the medical professional, this may result in the medical professional being suspended or struck off. Where there has been death of a patient as a result of medical treatment, an investigation in the form of an inquest will be held to determine the cause of death. The most extreme outcome of a medical malpractice or medical negligence claim would be a criminal charge of culpable homicide, which is negligently causing the death of another human being.

In cases where the plaintiff wins a case against the medical professional and/or their employer, monetary compensation is paid out[525]. A medical professional who has had to settle medical malpractice or medical negligence claim would see their indemnity cover premiums affected. This consequence has understandably led to medical doctors practicing 'safe medicine' in an attempt to fend off damages claims. Another consequence of the prominence of malpractice claims is that it inhibits medical doctors from branching out as indemnity premiums rise annually due to the increase in malpractice claims. According to the Medical Protection Society SA, there has been a 35% increase in claims against medical professionals between 2011 and 2016, with claims over one million rands seeing nearly a 550% increase compared to ten years before[526]. Claims over five million seen an increase of 900% from 2008 to 2013[527]. The rise in claims against medical professionals has also had the effect of increasing medical indemnity cover, which has, in turn, put medical professionals on the defensive. One of the most affected areas of

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525 Coetzee, L C & Carstens, P, "Medical Malpractice and Compensation in South Africa", Chicago-Kent Law Review, vol. 86, issue 3, 1263, June 2011

526 "Malpractice claims on the rise", Bizcommunity, April 2018. https://www.bizcommunity.com/Article/196/334/176029.html Accessed 4th March, 2023.

527 *Ibid*

medicine is the obstetrics sector. Obstetricians saw an increase from R250 000 per annum increase up to approximately *R 900 000 per annum*[528].

When one considers that the right to health is a fundamental right and that medical professionals have a legal and ethical duty of care, yet there are still cases of obvious medical malpractice and medical negligence which are not given their due urgency at the time, it is not surprising that medical malpractice claims are on the rise. When those affected are not given satisfactory reasons and information as to what led to an incident of medical malpractice or medical negligence as in Mr Ebrahim's case, the relationship of trust is broken, and this often leads to the affected seeking compensation via the courts, thus contributing to a rise in malpractice claims.

Justification for Selection of Countries under Study

The selection of medical malpractice regimes surveyed by this Study was based on the objective of this thesis; "To achieve this objective, there shall be a detailed analysis of the necessary applicable statutory laws, restatement of legal rules and analysis of cases in both the Nigerian and other jurisdictions where the principles of law are similar. It is hoped that at the end of this research there will be rise in awareness and literacy level and therefore there will certainly be rise in litigation and the like on medical cases in Nigeria".

Three groups of countries were considered: (1) Countries that compete with Nigeria within the same Continent; (2) Countries that have Islamic approach to medical malpractice; and (3) countries that have "best practices" medical malpractice regimes.

Because medical malpractice and liability of medical practitioners are an integral part of the social and cultural fabric of individual countries, it is difficult to select specific national

528 Mashego, P, *'Insurance cost puts doctors on defensive'*, Sunday Times, September 2018. https://www.pressreader.com/south-africa/sunday-times1107/20180923/282565904060020 Accessed 4th March, 2023.

examples as "best practice" which should then be applied to another country with a different culture, economy and government. However, the Organization of Economic Cooperation and Development (OECD), which consists of 30 countries with well developed economies, recently conducted a survey of medical malpractice and insurance issues in its members in an attempt to develop policy options for countries attempting to improve their medical malpractice and insurance regimes[529]. This survey is instructive.

One OECD country, the United Kingdom, was selected for comparison in this Study. Claims for medical malpractice are adjudicated based upon a determination of "fault" (breach of duty) and proof that medical error caused injury. In the United Kingdom, doctors working in National Health Service Hospitals are indemnified for malpractice by a state funded scheme. Insurance and other financial indemnification is required of private medical professionals and hospitals.

The Comparative analysis.

As discussed above, a plaintiff in a common law suit for medical negligence has to establish the four elements, to wit, a duty of care to the claimant, a breach of that duty, a harm alleged by the claimant caused by the breach[530].

Under the Saudi Arabian jurisdiction, the Law only required that the healthcare professional should 'exert due care in line with commonly established professional standards' without defining what that standard requires. The medical professional members of the *Shariah* Medical Panels determine the standard of care, on case to case basis, while the legal member (the judge) only determines the compensation or punitive measures.

When juxtaposed with the standard of care in the UK jurisdiction during pre Bolam era, the *Saudi Arabian* concept of standard is similar in that the medical professionals (who are usually

529 Medical Malpractice Prevention, Insurance and Coverage Options (OECD 2006).

530 *Ibid*

the defendants) set their own standard of care, determine if the patient owe them a duty of care, if they have breached that duty, and if the breach was in fact the cause of the harm which the complainant (patient) alleges. This allegation seems to be corroborated by this: "The problem in the Saudi legal system is that it allows every ministry, including the health, to handle claims against it in case of violations related to it and this gives the ministry of health the power to cover up for many mistakes done by medical practitioners".

When compared post Bolitho, the standard of care under the UK has now fallen within the ambit of the court's authority to determine the reasonableness of clinical judgment. That cannot yet be said of the Saudi standard of care. UK model of medical negligence emanated from a combination of case laws and statutes, the Saudi Arabian model is a creation of statute based on the *Sharia*. Additionally, although a claim in medical negligence is mainly a subcategory of tort of negligence, it may also arise from a breach of contractual duties or as a criminal offence. Conversely, all Saudi Arabian laws are based on the *Shariah law* which primarily emanated from the holy Qur'an and the *Sunnah* of Prophet Muhammad. The King passes statutes and acts in form of royal decrees that apply generally to the kingdom. A claim in medical negligence is a statutory creation via The Law of Practicing Healthcare Professions of 1426 (H) passed by a ministerial resolution pursuant to royal decree No. 59 of the year 1426 (H).

Nigeria and South African Law on Negligence is just the same with that of the British under the Common law. Having been colonized by the British, the Common Law became applicable in these jurisdictions, hence the rule in *Donoghue v Stevenson* which established the principle of duty of care and laid a foundation for the tort of negligence and not *Bolam Test*, is applicable.

The standard of care required of them is that of a reasonably competent practitioner in their branch of the profession faced with a similar situation, The test is whether a reasonably

competent practitioner in their position would have foreseen the likelihood of harm and taken steps to guard against it. This means that there is no legal liability for unforeseeable complications.

However, in South Africa, The courts do not accept *"res ipsa loquitur"* or the "*facts speak for themselves"* doctrine in medical cases unlike in Nigeria. The doctrine states that if some unexplained event occurs that does not normally happen unless somebody has been negligent the courts will infer negligence by that person unless he or she gives a reasonable explanation indicating that there was no negligence on their part. Thus it has been held that just because a swab was left inside a patient did not necessarily mean that the surgeon was negligent – negligence by the surgeon still had to be proved[531].

Medical negligence that amounts to unprofessional conduct may result in disciplinary action by the Health Professions Council of South Africa. Medical negligence causing death may result in a conviction for culpable homicide. Civil liability for damages may arise from negligent treatment or operations. Where the harm or injury arises from a negligent wrong (e.g. a negligent operation) the damages claimable are restricted to patrimonial loss or pecuniary damages that are measurable in monetary terms (e.g. loss of present and future earnings, present and future medical expenses, loss of support by dependants) as well as damages for loss of amenities of life, pain and suffering, etc. The object of these damages is to try to put the plaintiff back in the position that he or she would have been had the injury or harm not occurred, this is also applicable in Nigeria.

In Nigeria and under the Common Law, the defendant is afforded with a number of defenses to avoid liability. Those include contributory negligence, consent, *volenti non fit injuria,* unforeseeable risk, statute of limitation, or non-disclosure of essential information. Under the

531 *Van Wyk v Lewis 1924 AD 438*

Saudi Arabian law a claim may be statute barred if brought after one year of the knowledge of the negligent act unlike in Nigeria and the UK's three years. There is no negligence where the panel declares that it is a complication or side effect of medical treatments.

The Saudi law holds professionals personally liable in medical negligence; the employer is not vicariously liable even if the circumstance meets the common law criterion for vicarious liability[532]. Under the Common law and in Nigeria, even where the complainant succeeds, the professional may not become personally liable. The employer may be liable under the doctrine of vicarious liability if the negligent professional acted within the scope of his employment.

Unlike under the Common Law and in Nigeria, The Saudi Arabian *Law* is not specific on the standard of care required[533]. It stipulates that professionals should exert due care consistent with commonly established professional standards[534]. However, the test should be based on 'scientific and technical standards' contemporaneous to the negligence, not some obsolete standard applied in the present day. That could only be deduced from our review of the *Shariah* principles that the complainant must show that there was a breach of duty, harm and causation. It is not clear how to establish a duty of care.

5.4.LESSONS FOR NIGERIA

Medical Practice in Nigeria obviously differs from medical practice in other jurisdictions, especially in the jurisdictions comparatively analyzed above. For obvious reasons, Medical Practitioners, particularly medical doctors prefer to practice in these jurisdictions more than Nigeria. The lessons for Nigeria are to wit:

1. In the United Kingdom, an action for damages is usually targeted at the National Health Service, and not the medical practitioner. Once a case of medical negligence is

532 Article 27 *Ibid*
533 Article 26 *Ibid*
534 *Roe v Ministry of Health* 1954 2 QB 66

established, the aggrieved party sues the National Health Service and not the medical doctor. This is because the institution is to be held vicariously liable for the negligent actions of the medical practitioners in the United Kingdom. It is for this reason that the regulating institutions are stringent on issues concerning the employment of medical practitioners in the United Kingdom. Consequently, it is imperative for Nigeria to consider this model for purpose of regulating and closely monitoring the activities of the medical practitioners in Nigeria. This will ensure that the regulating and recruiting institutions are serious as they would be held accountable for the negligent and reckless actions of the medical doctors.

Furthermore, It is imperative to remark that the need for investing in the health sector of Nigeria cannot be overemphasized. The chief reason for which medical practitioners are always seeking for relocation to other medical jurisdictions is because of poor medical architecture in Nigeria. Whereas other jurisdictions have better, secure and clearly defined medical infrastructure and luring remuneration modules for their medical practitioners, Nigeria is busy embarking on medical tourism to these jurisdictions instead of fixing the medical system but would want to forestall or prohibit the medical practitioners from leaving the country.

CHAPTER SIX.
SUMMARY, CONCLUSION AND RECOMMENDATIONS.

6.1: SUMMARY

Medical negligence is a tortuous act that is found to arise from the relationship existing between the doctor or care giver and a patient[535]. This relationship stems from the duty of care and confidence that the medical profession like most other professions, is built on. A breach of the duty arising from this relationship by the doctor, exposes the doctor to liability for criminal breach of duty of care, a civil action either in tort or contract, and finally, exposes him to liability for professional misconduct by the Medical and Dental Practitioners Disciplinary Tribunal. In a civil action for medical negligence, it was also found that the hospital or the doctor is the proper defendant and the patient or his representative is the proper plaintiff[536].

Various acts of a doctor may give rise to an action in medical negligence. This thesis considered a number of such acts that amount to medical negligence in Nigeria and some foreign jurisdictions. These acts include inter *alia*, failure to attend and or give prompt medical attention; incorrect diagnosis; failure of communication; incorrect assessment of a patient; failure to take full medical history; errors in treating patients; improper administration of injection; and failure to get the consent of the patient etcetera.

Also, this thesis established that a plaintiff in an action for medical negligence must proof three necessary ingredients of the tort to it; that the defendant owed him a duty of care, that the

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535 M. S. Pandit and Shobha Pandit , *Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defense - A legal perspective*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7245980/ accessed, 24th March, 2023.

536 *Ibid*

defendant breached this duty of care, and that the breach occasioned the injury suffered by the plaintiff[537].

The standard of care is the measure against which the defendants conduct is assessed. It is an objective measure. In considering whether the standard of care was breached, the courts use the reasonable mans test. That is, the question whether the conduct of a person similarly situated. Professionals, for example, cannot escape liability by performing merely up to the capacity of the ordinarily prudent layperson. A lawyer is obliged to act like a reasonable prudent lawyer and a medical doctor is obliged to act like a reasonably prudent doctor. Rather than asking whether the performance was to the best of any particular defendant's ability, the courts assess whether the defendants conduct was up to the standard of a person of average competence in exercising their particular profession.[538] Duty is imposed by law and if breached, it is assumed that an injury has been visited upon a patient at the hands of a medical practitioner whose ultimate duty is to under all reasonable care provide relief or succor to the patient.

This research also took a long at the legal and institutional frameworks which guides medical practitioners in Nigeria, the necessary laws and institutions were x-rayed and such institutions are the Nigeria Medical Association, The Medical and Dental Practitioners Act, The Pharmacists Council of Nigeria Act, The National Health Act, The Nursing and Midwifery (Registration etc) Act among others.

The primary duty of a Medical Practitioner according to these Acts is to take care or to find cure for the ailment of a patient that may be put in his care. This duty has been recognized from time immemorial. The duty in this regard is usually said to be contractual. It is also one of the

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537 Oludamilola Adebola Adejumo *Legal perspectives on liability for medical negligence and malpractices in Nigeria*. Published online February 17th 2020.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7245980/ Accessed 24th March, 2023.

538 Negligence from Litigation and dispute resolution in Canada, http;//www.blakes.ca/DBIC/guide/Dispute/html/negligence.htm accessed on 20th, March 2023

incidents of various provisions of the Law put in place for the purpose of achieving this objective. Much as the duty is Contractual and some of the remedies that are usually found when there is a breach of Contract can be asked for in a relationship of a Medical Practitioner and patient, it is not unusual to ask for the remedies that are usually granted in the case of a delicit or a tort, the reason being on the dichotomy of Criminal and Civil aspects of Law. Thus, while it may be said that a Medical Practitioner accepts to treat a patient who presents himself to him for advice, diagnosis or cure by reason of which a contractual relationship is created, if however along the line, the Medical Practitioner is negligent in the performance of the duty of care he owes by reason of his position as a Medical Practitioner, he becomes liable to pay damages to the patient not necessarily by reason of the contractual nature of the duty, but by reason of the classification or characterization of the claim by the patient or his counsel, as in Tort, in consequence of which the matter is taken out of the confines of a contract and becomes a Tort. Therefore, the same act or relationship of a Medical Practitioner and patient may be regarded not only as contract but it may generically be called a contractual relationship that may give rise to a Tort.

The work went on to consider issues relating to evidence in the proof of medical negligence. It was found that the burden of proof in an action for medical negligence, as in every civil case, lies on the plaintiff who asserts negligence and who will fail if no evidence was given in the matter[539]. The standard of proof required of the plaintiff was also found to be on the balance of probability or on the preponderance of evidence[540]. It was also found, that the plaintiff in an action for medical negligence must plead particulars of negligence by itemizing the particular facts that form the ground for his claim in negligence. Failure to plead these particulars of

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539 Oludamilola Adebola Adejumo *Legal perspectives on liability for medical negligence and malpractices in Nigeria. Ibid.*

540 *Ibid*

negligence is detrimental to the case of the plaintiff as it means the plaintiff cannot lead evidence in proof of negligence.

Like every matter before Nigerian Courts, it was found that relevancy and admissibility of evidence in a medical negligence action is regulated by the provisions of the Evidence Act 2011. Various provisions of the Act can therefore be taken advantage of in proving the plaintiff's case. The plaintiff may use any type of relevant and admissible evidence to proof his claim. It was however found that certain pieces of evidence are by existing authorities, most useful to a plaintiff in medical negligence cases. They are the evidence of expert witnesses, the presumption of negligence raised by the doctrine of *res ipsa loquitur* . The evidence of expert witnesses was found to be admissible and perhaps, the most useful piece of evidence in a case of medical negligence.

Expert testimony is also useful in proving causation in medical negligence cases. It was however found that due to the "conspiracy of silence" amongst Doctors, litigants hardly get willing witnesses to testify on their behalf and when they do, they do so for a fee, which renders their evidence to carry less weight in the eyes of the law.

On the doctrine of *res ipsa loquitur*, it was found that the doctrine raises a presumption within the meaning of the evidence act, that the defendant Doctor, did breach the duty of care he owed the plaintiff and which breach caused the injury suffered by the plaintiff. Being a rebuttable presumption of law, the defendant may however lead cogent evidence to displace the presumption which only applies as a prima facie proof of negligence upon proof first, of the facts of the negligence.

For the doctrine of *res ipsa loquitur* to be operative, it was found that there must be proof of the happening of an unexplained occurrence which would not have happened in the ordinary

course[541] of things without negligence on the part of somebody other than the plaintiff and the circumstance must point to the negligence in question being that of the defendant. For the plaintiff to rely on the doctrine, he must specifically lead facts that support the maxim and which pleading must be supported by credible evidence. This doctrine has been found to be of great use to a plaintiff in medical negligence cases, as going from the authorities, cases of medical negligence had been resolved in favour of the plaintiff on the basis of the doctrine of *res ipsa loquitur* alone[542].

Although this work focused basically on the negligence of Medical Doctors, other professionals involved in the provision of health care can also be liable for negligence where their acts amount to negligence within the meaning of the law as discussed above. The findings of this work with respect to the ingredients of negligence and the proof of same, also applies to other Medical Practitioners like pharmacists, nurses, etc. They may be proceeded against independently where their acts alone caused the injury to the patient, or they may be sued jointly with the Doctor where it is their act in conjunction with that of the Doctor that caused the damage complained of. The patient hence has a wide range of persons he can proceed against for negligence in case of breaches, so long as he can proof the legal requirements for same.

This research also set out to explore and conduct a comparative analysis of the concept of medical negligence as applicable under the United Kingdom, Saudi Arabia and South African jurisdictions. That is, the laws governing medical negligence and the rules of procedures (process) of litigating claims in medical negligence were examined.

It was found that United Kingdom, South Africa and Saudi Arabian legal system have different sources and histories. The English common law applies in the United Kingdom and South Africa

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541 *Barnett v Chelsea and Kessington Hospital Management Committee*. (1969) 1 QB, 178.

542 *Ibid*

while the *Shariah* law applies in Saudi Arabia. In spite of those major differences, it is noteworthy that the rate of medical negligence claims in these jurisdictions has been monumentally growing each evolving year.

Also, these jurisdictions bear similar concepts of medical negligence, and are in agreement that healthcare professionals must be accountable for their actions and/or inactions that result in harm to others.

6.2: CONCLUSION

In conclusion, this work has established in a most detailed way, the entire province of the proof of medical negligence under Nigerian law. It has analysed the nature of the tort of medical negligence under Nigerian law, the various ingredients of the tort of medical negligence and the various pieces of evidence in proof of a medical negligence claim.

It is clear that there exist a duty of care in a doctor-patient relationship. This sacrosanct duty imposed by law if breached assumes that injury has been visited upon a patient at the hands of a medical practitioner, whose ultimate duty is to under all reasonable care provide relief or succor to the patient. The breach of the basic duty of care cannot simply be wished away or over emphasized; the victims are most often subjected to physical or emotional instability and trauma for the rest of their lives on such occasions where death does not arise as a result of such malpractice. It is necessary to reiterate the fact that medical practitioners need to abide by the principles guiding their profession as failure to abide by these time-honored principles may lead to drastic career truncation, damages for medical negligence and even criminal liability.

As seen above, the fact that negligence cannot be proved will not leave a patient without other legal remedies, as may be deemed appropriate. Notwithstanding the above, the law protects the medical practitioners to the extent that liability for criminal negligence must be proved beyond

reasonable doubt and also, in civil cases, the 'reasonable man's test' is deemed to be largely protective of the medical practitioner over and above the patient to a large extent. In all, the need to relieve the victim who has to incur litigation expenses and suffer the rigours of litigation must be emphasized. This can be done, for instance, in Nigeria by the adopting of the 'no fault' compensation scheme as is being done in South Africa. This scheme relieves patients of the need to establish fault on the part of the medical practitioner once injury is suffered. *The UK NHR Redress Act 2006* which introduces the redress scheme as an alternative to litigation in less severe cases of negligence are also recommended for adoption in other jurisdictions to relieve patients of the rigours of litigation in certain cases where negligence is apparent. There is also a need to review the criminal laws on negligence resulting to manslaughter to distinguish between cases of recklessness and cases of criminal negligence arising from sheer ignorance or incompetence

Finally, it should be noted that the law places high premium on ensuring that best healthcare practices are obtainable in our hospitals[543] and generally health institutions. It is therefore important that patients know they have inalienable rights as to what to expect in terms of treatment.

6.3 RECOMMENDATIONS

In view of the above mentioned as regards the Breach of Duty as evident amongst Medical Practitioners, I make the following recommendations:

1. Contrary to the move by the Federal Government through the National Assembly to legislate on prohibiting Nigerian trained Medical Doctors from travelling abroad for medical practice which is strongly viewed as a gross violation of the provisions of the Constitution of

[543] The passing of the National Health Bill by the national assembly in 2014

the Federal Republic of Nigeria on Fundamental Human Rights, the Federal Government should channel energy towards placing a ban or prohibiting Members of the National Assembly and Nigerian Political Office holders from traveling abroad on medical tourism. Secondly, the Federal Government should look in the direction of investing in the health sector of the Nigerian economy so as to provide sufficient medical equipments and adequate medical infrastructure for the various hospitals in Nigeria. In addition to the, adequate remuneration and a robust working environment and conditions should be made available to he medical practitioners at all levels.

2. The Medical Practitioners should adhere strictly to the Geneva Declaration which makes us understand that they must maintain a universally acceptable professional standard of practice as well as meet the demands of practice.
3. Nigerians should also be aware of Medical quackery. In essence, the Nigerian Medical Council with the Courts should take strict measure in eradicating quackery in Medical Practice. The Court should discourage the act by penalizing the offenders which will in turn serve as deterrence to other intending quacks.
4. The Medical Disciplinary Tribunal should be independent. Independent in the sense that they should be free from the Court inferring with their duties. This will enable the Practitioner to ensure that their Conduct is in accordance with the stipulated standard expected of them in the practice of their Profession.
5. A Law should be put in place for free Litigation Service because in Nigeria as regards Medical Care there is paucity of cases basically because Litigation fee is a mitigating factor for those who really want to express their grievance in the Court of Law. In the United Kingdom there is a provision on Conditional fee arrangement of Legal Services for victims

of Medical Negligence in their Court[544]. The Nigerian Legislature should enact a Law as regards free arrangements so that lack of money will not be a reason for not instituting an action.

6. More so, the entire Nigerian populace should be enlightened as to the Rights they have as Citizens. It is observed that due to our cultural background, people are not readily disposed to Litigation. It is generally believed in Africa that resorts should not be heard to the judicial process particularly against known persons. This belief is predicated on the axiom that 'there can no longer be friendship after Litigation'. Africans prefer to leave judgment to God rather than fight for their rights. In relation to this, a program should be organized to awaken the entire populace of their Medical Rights.
7. In conclusion, Medical Practitioners should be cautious in carrying out their duties, they should act the way any reasonable person should act. They should try their possible best not to fall short of their Code of Conduct either by their acts or omission as regards the Conduct expected among Practitioners. They should not neglect or disregard professional responsibilities to patients for their care and treatment. Their behaviour should not be derogatory to the reputation of the Medical Profession such as drug abuse and they should not abuse professional privileges and skills given to them.
8. On the problem of expert evidence, the Nigerian Medical Association should be encouraged not to clamp down on any of its members who testifies for victims (this is referred to as bottleneck syndrome among the medical profession) against a Medical doctor. This will encourage high standard practice among medical practitioners and will help eliminate the "conspiracy of silence" among medical doctors in actions against their colleague.

[544] United Kingdom Legal Service Act 1990

9. Medical law as a course of study for lawyers should be introduced at the undergraduate level so that lawyers are properly equipped to handle technical issues involved in medical negligence cases. Lawyers should also pursue specialising in this area of the law. It is strongly believed that if lawyers are well equipped to handle medical negligence cases, it will improve the lot of litigants in this area of law.
10. There is the need to reform the law of tort in Nigeria. This is because; the usual way for seeking redress for damage suffered resulting from medical negligence is the current tort system is frustrating because of reliance on common law, which has increasingly been subjected to criticisms.
11. The Medical and Dental Practitioners Tribunal's composition, operations and methodology requires statutory and institutional over haul. It is apparent that reported cases of lack of fair hearing and instances of members who did not participate in all sittings of the Tribunal are leading to situations where decisions of the Tribunal are set aside on appeal. The Medical and Dental Practitioner's Act merely requires that two out of the ten members of the Tribunal should be medical and dental practitioners; it does not make provision for a member who is knowledgeable in law or qualified to practice law in Nigeria. The operation of the Tribunal will be more effective and effectual if at least one of the members is a legal practitioner who is qualified under the Legal Practitioner's Act. The Tribunal's operation should be given wide publicity to ensure transparency and deterrent to erring medical practitioners.

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