MEDICAL MALPRACTICES AND NEGLIGENCE: LAW TO THE RESCUE

BEING A PAPER

Delivered by
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INTRODUCTION:

I am immensely grateful to the NIGERIA BAR ASSOCIATION (IBADAN BRANCH) through its quite unassuming but effective, efficient and charming chairman MR IBRAHIM LAWAL the NBA Ibadan Branch Chairman and the Planning Committee Chairman of the PLATINUM JUBILEE (70TH ANNIVERSARY) OF THE IBADAN BRANCH OF THE NIGERIAN BAR ASSOCIATION in person of ever cheerful ASIWAJU MUTALUBI OJO ADEBAYO SAN, and all the Anniversary Committee Members for affording me the privilege and opportunity to be the Lead Speaker at the OWOLABI AFUYE MEMORIAL LECTURE on the topic - **"MEDICAL MALPRACTICES AND NEGLIGENCE; LAW TO THE RESCUE"** under the theme - **LAW, LEGAL PRACTICE AND DEVELOPMENT.**

DEFINITION OF WORDS:

I believe it is necessary for me to examine and explore the meaning or definition(s) ascribable to the key words in the topic which to my mind are – "medical malpractice" and "negligence"

Black's Law Dictionary at page 1148 defines "MEDICAL MALPRACTICE" as:

> **" A doctor's failure to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances."**[1]

The same **Black's Law Dictionary defines "Negligence"** on page 1245 as:

> **"The failure to exercise the standard of care that a reasonably prudent person would have excised in a similar situation; any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wilfully disregardful of others rights, the doing of what a reasonable and prudent person would not do under the particulars circumstances or the failure to do what such a person would do under circumstances."**[2]

The **Black's Law Dictionary** goes further in its elucidation on Negligence to state that:

> **"The elements necessary to recover damage for negligence are (1) the existence of a duty on the part of the defendant to protect the Plaintiff from the injury complained of and (2)**

[1] HC Black and Brian A Garner, *Black's Law Dictionary* (Brian A Garner ed, Eleventh, Thomas Reuters 2021).
[2] Black and Garner (n 1).

an injury to the plaintiff from the defendant's failure. The term denotes culpable carelessness"

In the Nigerian Law Dictionary by Suleiman I. NCHI at page 1146 viz:

"medical malpractice. The failure of a doctor, pharmacist, or some other medical professional to exercise the degree of skill and care that a physician, surgeon, pharmacist, or other medical professional of the same medical specialty would use under similar circumstances."[3]

In the Code of Medical Ethics in Nigeria, 2008, Rule 33.0 thereof, it is evident that the Medical and Dental Council of Nigeria abhors all forms of Medical Malpractices on the part of a Medical and Dental Practitioners in Nigeria. This is strongly underscored in said Rule 33.00 of Code of Medical Ethics In Nigeria 2008 which provides:

"33.0 MALPRACTICE IN A GENERAL RESPECT

The practice of medicine or dentistry as appropriate shall be conducted in accordance with standards, decorum and by methods that are judged acceptable and appropriate by the generality of registered members of the medical and dental professions. Such acceptable standards, decorum and methods are in accordance with the knowledge, skill and practice as imparted in institutions that are recognized for medical and dental training by the Medical and Dental Council of Nigeria.

When any aspect or area of professional practice as conducted by a registered practitioner is called to question to the information or knowledge of the Medical and Dental Council of Nigeria, by an aggrieved person or by a colleague, or by any other means whatsoever, that aspect or area of the practice or professional relationship, and any other relevant matters, shall be examined within the context of the provisions of the Medical and Dental Practitioners Act. Such a medical or dental practitioner, who is thus found, by the statutory procedure, to have failed to meet the professionally accepted standards, method or decorum, shall be guilty of malpractice. For this reason, every medical or

[3] SI Nchi, DCJ Dakas and AN Waya, *The Nigerian Law Dictionary* (Tamaza Publishing Company 1996) <https://books.google.com.ng/books?id=Xk1uAAAACAAJ>.

dental practitioner should know his limitations, in terms of skills and facilities, and should not take on cases, which he cannot effectively handle.

It shall be the duty of medical and dental practitioners to report every case to the appropriate authorities including the Medical and Dental Council of Nigeria. Failure to report any such case may render the registered practitioner in charge of such institutions primarily liable for an infamous conduct in a professional respect."[4]

The Code of Medical Ethics comprehensively provided and prescribed for each Practitioner Declaration, Pledge and Allegiance to faithfully practice his/her profession to the best of his/her ability and knowledge.

"…for the good safety and welfare of all persons committing themselves to my care and attention and that I will faithfully obey 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 professions in Nigeria.[5]

MEDICAL OATHS:

The Declaration, Physician's Oath and pledge are contained on pages 71- 72 appendix 1 to the Code, they are as follows:

"I Solemnly Pledge

To consecrate my life to the service of humanity:

1. **I WILL GIVE to my teachers the respect and gratitude that is their due;**
2. **I WILL PRACTISE my profession with conscience and dignity;**
3. **THE HEALTH OF MY PATIENT will be my first consideration:**
4. **I WILL RESPECT the secrets that are confided in me, even after the patient has died,**
5. **I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;**
6. **MY COLLEAGUES will be my sisters and brothers;**

[4] 'Code of Medical Ethics In Nigeria' (2008) <https://www.mdcnigeria.org/downloads/code-of-conducts.pdf> accessed 15 December 2024.

[5] 'Code of Medical Ethics In Nigeria' (n 4).

7. **I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;**
8. **I WILL MAINTAIN the utmost respect for human life:**
9. **I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;**
10. **I MAKE THESE PROMISES solemnly, freely and upon my honour.**

The Declaration of Geneva (Physicians' Oath Declaration)

……..

Signature of the Doctor or Dentist who has taken the Oath

……..

Signature of the Provost or Dean of the College or Faculty of Medical or Health Sciences (The signature of the Head of the training institution would not be required on the Attestation Forms of graduates whose training Institutions are outside Nigeria)

Date…….....”[6]

The Code on Medical Ethics also makes it compulsory that all Medical Doctors and Dentists are duty bound to familiarize themselves with the law setting up Medical and Dental Council of Nigeria which is referred to as:

> **“…statutory arm and the regulatory body set up by law and Medical Association referred to in the Code on Medical Ethics as “ a quasi-voluntary association of all medical doctors and dentists.”**

They are also enjoined to be abreast of the provisions of Medical and Dental Practitioners Act Cap M8 2004.

Medical malpractice and negligence are critical issues that plague healthcare systems worldwide, particularly with some alarming manifestations in Nigeria. As noted by a learned writer ***Maryam Abdulsalam*** in her article titled, ***“A Review Of Medical Negligence In The Nigerian Healthcare Sector: Utilising The Law As A Panacea”*** **she said:**

[6] ‘Code of Medical Ethics In Nigeria’ (n 4).

"over the years, there have been innumerable reports of physical injury and deaths arising from the negligence of doctors, nurses, pharmacists, anaesthesiologists, other medical practitioners, and hospitals generally. The various cases (reported and unreported) of medical negligence are an indictment of Nigeria's healthcare sector, which has been described as decayed and terribly poor.

As a result of the appalling state of the healthcare sector, some Nigerians with means prefer to travel outside the country for medical treatment, but a large percentage of Nigerians are stuck with using the deplorable healthcare facilities offered by the 'Giant of Africa'. This is an unfortunate situation, and it is worsened by the lack of awareness on the part of healthcare users. The average Nigerian is not aware of the duties owed to him or her medical practitioners, much less the fact that when these duties are breached, there is room for legal redress."

INTERVENTION OF THE FEDERAL GOVERNMENT VIA ACTS AND REGULATIONS

In order to stem the tide of Medical Malpractice /negligence and other professional misconducts and all embracing efforts to protect the lives and health of its citizenry many laws have been passed by Federal Government of Nigeria to regulate Medical Practice. Code of Conduct were also put in place to guide Medical and Dental Practitioners in attending to patients and all who seek healing vide orthodox medicine. Hence the emergence of the following:

1. **MEDICAL AND DENTAL PRACTITIONERS ACT CAP M8 2004:**

   This is the Act which provides for the establishment of the Medical and Dental Council of Nigeria for the registration of Medical Practitioners and Dental Surgeons and the provision for a Disciplinary Tribunal for the discipline of members which came into operation on 28/6/1988.

   The Law created the Medical and Dental Council of Nigeria known as "the Council" charged with the following responsibilities:

   "1.(2) The Council shall have responsibility for

   (a) 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

(b) Securing in accordance with the provisions of this Act, 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;

(c) 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

(d) supervising and controlling the practice of homeopathy and other forms of alternative medicine.

(e) making regulations for the operation of clinical laboratory practice in the field of Pathology which includes Histopathology, Forensic Pathology, Autopsy and Cytology, Clinical Cytogenetics, Haematology, Medical Micro-biology and Medical Parasitology, Chemical Pathology, Clinical Chemistry, Immunology and Medical Virology, and

(f) performing the other functions conferred on the Council by this Act"[7]

2. **THE CODE OF MEDICAL ETHICS IN NIGERIA**:

This was published in 2008 by the Medical and Dental Council of Nigeria pursuant to section 1(2)(c) of the MEDICAL AND DENTAL PRACTIONERS ACT already produced above. The objective of the code is to inculcate in the medical and dental professions "ethical statement developed primarily for the protection /benefit of the patient". Medical and Dental profession shall place their responsibility to patients above every other consideration (Preamble Rule 1)

Rule 2 is the OBJECTIVE OF THE CODE OF CONDUCT which reads:

"2.1. To enable medical and dental practitioners in Nigeria to maintain correct attitude universally expected of physicians.

2.2. To meet the prescriptions of the Medical and Dental Council of Nigeria with regards to ethics and the quality of professional practice

[7] Medical And Dental Practitioners Act.

2.3 To ensure that all medical and dental practitioners carry on their professional duties in a manner that earns the trust of the patient and the respect of the society for the profession.
2.4 To let the public know what they can expect from doctors.
2.5 Amongst other uses, it shall be used by the disciplinary organs of Council to determine professional conduct."

3. NATIONAL HEALTH ACT 2014:
   The objective of the Act is to provide a framework for the regulations, development and management of a health system and set standard for rendering health services in the Federation; and other matters connected therewith. It came into effect on 31st October 2014.
4. NATIONAL HEALTH INSURANCE SCHEME ACT (2004):
   The Act established the National Health Insurance Scheme for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost-effective health services as set out in the Act.
5. NURSING AND MIDWIFERY (REGISTRATION ETC) ACT 1979
6. THE CONSTITUTION OF THE FEDERAL REPUBLIC OF NIGERIA 1999 AS AMENDED.
   All the Acts and laws mentioned above derived their efficacy from the Constitution of Nigerian aforesaid.

The topic of this paper has been circumscribed by the title which is "Medical Malpractices and Negligence; Law to the Rescue"

As stated herein, "Medical Malpractice" which is a doctors failure to exercise the degree of care and skill that a physician or surgeon must possess is more or less coterminous with the word "Negligence" which is also defined in the **Nigerian Law Dictionary** as:

> **"unreasonable omission to perform a duty resulting in damages or injury to another; conduct that is the result of the careless or deliberate disregard of the rights of others; an act of causing damage to others by failure to use such care as a reasonable and prudent person would use in similar circumstances."[8]**

In effect, we are concerned about the hazard a Medical or Dental Practitioner can cause to the health and wellbeing of his patient in the course of medical

[8] Nchi, Dakas and Waya (n 3).

treatment or examination within the contexts of the laws guiding the relationship of a Medical Practitioner and Dental Surgeon and his patient and the general public.

INVENTORY OF PROFESSIONAL NEGLIGENCE WHICH DOCTORS AND DENTAL SURGEON MAY BE LIABLE

Now the Medical and Dental Council of Nigeria vide the Code of Medical Ethics in Nigeria strictly and solemnly admonished all medical and Dental Practitioners to operate within the bounds of sound Professional Conduct encapsulated under the aegis of PROFESSIONAL BRETHREN OF GOOD REPUTE AND COMPETENCY as contained in Rule 26 of the Code of Medical Ethics which provides in part:

> **"In all areas of their professional practice, conduct and comportment, in their professional and other relationships with their patients as well as other persons, including colleagues, all registered medical and dental practitioners shall be guided and bound by sound ethical practice. The general principle is that when a medical or dental practitioner, in the pursuit of his profession, has conducted himself in such a manner which would be regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then he is guilty of infamous conduct in a professional respect. The list of acts that constitute infamous conduct in a professional respect is not exhaustive because the profession demands the highest ethical standard from its members. The acts listed in this code must therefore be regarded as examples of conduct which members of the professional must avoid."**[9]

It provides also that the Disciplinary Tribunal can impose any of the following statutory penalties upon conviction for infamous conduct depending upon the gravity of the offence and the attitude of the practitioner before and during the investigation and or trial. Viz

> **"Rule 26(1) Order the Registrar to strike out the person's name of the relevant register or registers.**

[9] 'Code of Medical Ethics In Nigeria' (n 4).

Rule 26(2) suspend the person from practice for a period specified in the directive, not exceeding six months

Rule 26(3) Admonish the person"

Among the acts that constitute professional Negligence can be found in Rule 29. ***PROFESSIONAL NEGLIGENCE:***

"The medical and dental practitioner's duty is to care for their patients in every professional relationship. The particular skill which training. recognition and registration bestow on a practitioner should be exercised in a manner expected of any other member of the profession of his or her experience and status. In the light of the rapid advances in science and medicine, it has become necessary for practitioners to regularly upgrade their knowledge and skills through activities of continuing professional development (CPD). Evidence of having participated in CPD activities has become a necessary condition for the renewal of practising licences based on the guidelines determined by the Council from time to time. A practitioner shall see and attend to ail patients on admission under his care, as frequently as their conditions demand, and record in the case notes relevant clinical findings at each visit Practitioners should take note of this following guidelines with respect to the category of patients listed hereunder;

29.1 Patients on Intravenous Therapy

29.1a All patients on intravenous therapy, and particularly blood transfusion, should be within the sight of qualified supervising clinicians at all times, and must not be left in the care of untrained individuals in a side ward even when they are relatives.

29.1b Obligatory observations of the pulse rate, blood pressure, temperature, and respiration must be charted at least every 4 hours, and 24-hour fluid balance chart should be kept and reviewed together with possible electrolyte changes every 24 hours.

29.2 Nursing The Unconscious Patient

Nursing of unconscious patient is a special science requiring the careful positioning, the observation and charting of

certain vital signs, and the patient should be in the view of the qualified supervising clinicians at all times.

29.3 Emergency Admissions

Every emergency admission should be seen by the doctor or dentist on call immediately, certainly not later than 4 hours after admission, and where appropriate, by the Consultant on call within 12 hours.

At the scene of a road traffic accident, a passing doctor is under no obligation to stop and render professional services to the victims; but if he decides to stop and do so, he is bound by the ethics to exercise a degree of reasonable care and do everything that a competent and registered practitioner would do in the circumstance.

There are peculiar infrastructural and social problems in Nigeria that are outside the control of medical and dental professions, which create obstacles to the ability of the clinicians of these professions to apply their expertise to the full degree expected; this situation does not preclude the practitioner from acting within the degree of reasonable care that is possible under the circumstances.

Thus a registered practitioner who fails to exercise the skill or act with the degree of care expected of his experience and status in the process of attending to a patient is liable for professional negligence.

29.4 The following among others constitute Professional Negligence

29.4a Failure to attend promptly to a patient requiring urgent attention when the practitioner was in a position to do so.

29.4b Manifestation of incompetence in the assessment of a patient.

29.4c Making an incorrect diagnosis particularly when the clinical features were so glaring that no reasonable skilful practitioner could have failed to notice them.

With respect to 29.4c see the cases of:

1. GEORGE ABI V. CBN & ORS (2012) 3 NWLR (PART 1286) 1 at 41 F-H to 43A-C per NWODO, JCA who said:

"The appellant failed to lead evidence to show 1st respondent is vicariously liable. The Abuja clinic was one of the retainer hospital provided by the 1st respondent for their staff. Appellant went to the clinic for treatment. The fact that 1st respondent paid for the treatment cannot be described as lack of care for the appellant rather compliance to contractual obligation on payment for treating a staff. There is no evidence 1st respondent instructed the 3rd respondent to cause appellant injury. The uncontradicted evidence on the standard of the hospital is that it is ranked high in the league of hospitals. In medical negligence claim, the onus is on the plaintiff to establish the negligence. Appellant was diagnosed with meningitis and was given gentamycin. The side effect is not pleasant but it amounts to a doctor balancing the risk. It is for the appellant to establish want of care, that a reasonable person in that profession would not have given him that drug. When he adduces evidence uncontradicted to show that the 3rd respondent's prescription of drugs including gentamycin and the administration of the drug by the staff of the hospital falls short of the standard of a reasonably skilful medical man, then he would have discharged the standard.

This is the crux of the claim on medical negligence. The appellant's case must be on want of care by the respondents. His claim is not on lack of information by the 3rd respondent on the side effect of gentamycin. What the appellant need was to call an expert skilled medical witness to testify on whether the prescription of gentamycin in the circumstance of the health condition of the appellant was right and whether it did cause appellant to become deaf. Whether a reasonable medical mind will say there was a mistake. Failure of the appellant to call an expert witness affected the claim.

Therefore I have no reason to interfere with the decision of the court below. There must be evidence to show that the appellant became deaf due to lack of diligence in prescription, administration and consumption of the drugs,

in particular gentamycin. In most cases, drugs manufacturers will clearly state its side effects in the packets bought from the pharmacy but when administered in hospital the patient hardly has the opportunity to know of the side effects unless told. It is only a reasonable/responsible medical expert in that field of medicine that can explain medically in evidence the benefit and risk of the drug for the judge to assess and weigh between two doctors' evidence. The presumption is that a judge is not a medical doctor, he can only assess evidence presented before her. On the appellant's claims for special damages, I agree with the submission of the learned counsel for the 1st respondent that claims for special damages must be particularized and proved with strict particulars. See C.A.P Pl v. Vital Investment Ltd. (2006) 6 NWLR (Pt. 976) CA 220.

Special damages are quantifiable pecuniary losses up to the time of trial at which time the exact amount to claim is known. On the other hand, general damages cover losses which are not capable of exact quantification. They do not need to be specifically pleaded although some evidence of the damage is required.

The appellant did not particularize his claim under special damages with specific heads. It is insufficient to merely plead as appellant did that on the face of daily crashing of the value of the naira he requires N500 million for maintenance of self and family and cost of seeking medical solution. The claim under special damages must be specific and direct.

The appellant will be paid damages if the wrong against him has been established. In the event that he did not discharge the burden of proof on him, the court cannot grant a remedy by ordering damages when there is no wrong established. Issue four is resolved against the appellant.

I wish to just observe that claims founded on medical negligence have been known to be difficult to establish and expensive as well. The evidence to be adduced by the injured usually is in the domain of the hospital and doctors.

Where records in the hospital are tendered in court it does not have much impact. The injured will inevitably rely on expert testimony to tell the court whether a reasonable person in the position of the doctor would have made the same diagnosis, treatment or procedure adopted.

Nevertheless, the circumstances of the appellant required some compassion and assistance from all the parties concerned."

2. DR GODI MILAM V MEDICAL AND DENTAL PRACTITIONERS INVESTIGATION PANEL & ANOR (2018) LPELR – 45539 (CA) 1 at 4D

The wound dressing was noted to be stained by blood. The doctors diagnosed "anaemic heart failure" yet there is no evidence that they reconsidered the question of continuing blood loss, and why she should go into that extreme state of "anaemic heart failure" and renal shutdown when the loss was only 800 millilitres...." It is not in doubt that the deceased patient did not have any preexisting disease of the heart, kidney or blood forming organs, but the Appellant and his colleagues diagnosed that she had "anaemic heart failure". See Exhibit 7, page 301. The only reasonable conclusion, as rightly reached by the tribunal is that the "anaemia were the result of severe haemorrhage resulting from the operation performed by Dr. Milam and Fom-Dom." I believe the tribunal was on the right footing when it held at page 217 of the record that "the diagnoses favored by the doctors in describing the patient's plight as "anaemic heart failure" and "acute renal (or kidney) failure with background of anemia" were unfortunately drawing the attention to the complications rather than the real cause of the problem: severe, acute haemorrhage, and making the doctors concentrate their attention on the wrong factors".

Contrary to the erroneous contention of the learned Counsel for the Appellant, it is evident that the opinion of the tribunal is borne out of the evidence before it. It is to be noted that the professional competence, skill, knowledge and experience of the Appellant as a Registered Medical Practitioner of Fifteen Years' Experience was in question,

and the Appellant gave evidence before the Tribunal, alongside with the entries he made in Exhibit 7 disclosing how he handled the patient when she was under his care. Rule 28 and of the Code on Medical Ethics, 2004 clearly states that manifestation of incompetence in the assessment of a patient; making an incorrect diagnosis particularly when the clinical features were so glaring that no reasonable skillful practitioner could have failed to notice them; failure to do anything that ought reasonably to have been done under any circumstance for the good of the patient, all constitute professional evidence. In the instant case, there is evidence on record establishing the fact that the operation of Bilateral Tubal Ligation (BTL) carried out by the Appellant was not justified. The fact that the Complainant and the deceased consented to the procedure does not free the Appellant from responsibility, as it is obvious that same was suggested by the Appellant, without any indication on record warranting the procedure. It is not enough for the Appellant to argue that the Complainant and the deceased were counselled and consented to the procedure, a necessity for the procedure must be shown to be justified by the Appellant, and in this case, the evidence shows the contrary. Given that the statutory function of the Tribunal is protective, it follows that the tribunal must form its own views on the totality of the evidence before it. The Appellant did not dispute the fact that blood was not readily available for use in case of emergency, notwithstanding the glaring fact that the medical history of the deceased patient is well known to them, as discernible from Exhibit 7. The tribunal was therefore also correct in finding the Appellant culpable. Before concluding this judgment, I find it expedient to consider the Appellant's argument that since the complainant did not have any complain against the appellant, therefore there was no reason for the Appellant to be charged before the Tribunal, I must say that this argument is misconceived, having regard to the relevant provisions of Section 15(3) of Medical and Dental

Practitioners Act, establishing the Medical and Dental Practitioners Investigating Panel, headed by the 1st Respondent, and empowering it to conduct preliminary investigation into any case where it is alleged that a registered person has misbehaved in his capacity as a medical practitioner or dental surgeon, or should for any other reason be subject of proceedings before the Disciplinary Tribunal. I am unable to accept the Appellant's submission that the 1st Respondent is limited only to file charges against persons against whom the complainant has levelled allegations of professional misconduct. This view cannot hold especially considering the instant situation where, though a complaint is made out against one person, it is nonetheless found that another person should also be a subject of the complaint. On the whole therefore, it is my view, that the 1st Respondent is empowered to conduct investigation and bring before the tribunal any medical practitioner or dental surgeon who is alleged to have committed professional misconduct in his professional capacity

29.4d 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, or function."

One can cite the pathetic story rendered in the case of **HATCHER V BLACK & OTHERS (1954)**[10] where a Mrs Hatcher, a lady who occasionally was broadcasting for BBC. she approached ST Batholomew's Hospital where it was diagnosed that she suffered from a toxic thyroid gland. And was advised. She asked if her voice was at any risk, the doctors at the Hospital reassured her that there was no problem or risk. The operation was performed and there was huge problem. In the course of the surgical operation her nerve was badly damaged that she could not speak properly thereafter. Her broadcasting career came to an abrupt end. It was a trial

[10] HATCHER V BLACK & OTHERS, The Times (July 2, 1954) per Lord Denning on Duty of Care

with jury. The summing up to the Jury by Lord Denning and the verdict returned is quite intriguing and interesting. Lord Dennings said:

> **Before I consider the individual facts, I ought to explain to you the law on this matter of negligence against doctors and hospitals. Mr. Marven Everett sought to liken the case against a hospital to a motor-car accident or to an accident in a factory. That is the wrong approach. In the case of an accident on the road, there ought not to be any accident if everyone used proper care; and the same applies in a factory; but in a hospital, when a person who is ill goes in for treatment, there is always some risk, no matter what care is used. Every surgical operation involves risks. 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 for ever looking over his shoulder to see if someone was coming up with a dagger - for an action for negligence against a doctor is for him like unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body.**
>
> **You must not, therefore, find him negligent simply because something happens to go wrong; if, for instance, one of the risks inherent in an operation actually takes place or some complication ensues which lessens or takes away the benefits that were hoped for, or if in a matter of opinion he makes an error of judgment. You should only find him guilty of negligence when he falls short of the standard of a reasonably skilful medical man, in short, when he is deserving of censure for negligence in a medical man is deserving of censure.**
>
> **Let me illustrate this by the vexed question which has been discussed in this case: What should the doctor tell his patient? Mr. Tuckwell admitted that on the evening before**

the operation he told the plaintiff that there was no risk to her voice, when he knew that there was some slight risk, but that he did it for her own good because it was of vital importance that she should not worry. In short, he told a lie, but he did it because he thought in the circumstances it was justifiable. If this were a court of morals, that would raise a nice question on which moralists and theologians have differed for centuries. Some hold that it is never permissible to tell a lie even for a just cause: a good end, they say, does not justify a bad means. You must not do a little wrong in order to do a great right. Others, however, hold that it is permissible, if the justification is strong enough, and they point to the stratagems used in war to deceive the enemy.

This, however, is not a court of morals but a court of law, and the law leaves this question of morals to the conscience of the doctor himself - though I may perhaps remark that if Doctors have too easy a conscience on this matter they may in time lose the confidence of the patient, which is the basis of all good medicine. But so far as the law is concerned it does not condemn the doctor when it only does that which many a wise and good doctor so placed would do. It only condemns him when he falls short of the accepted standards of a great profession; in short, when he is deserving of censure. No one of the doctors that have been called before you has suggested that Mr. Tuckwell did wrong. All agree that it was a matter for his own judgment. They did not condemn him; nor should we'.

I remember how anxious the doctors and nurses were. It showed on their faces. I remember how long the jury were out. It was 3 or 4 hours. They came back and found a verdict for the defendants. I was relieved. The law was on the right course. It has remained so. It is, I believe, very different in the United States of America. 'Medical malpractice' suits there have become the curse of the medical profession. The legal profession get 'contingency fees'. So they take up cases on speculation. The jury gives enormous damages. Insurance

premiums are high. The doctors charge large fees to cover them. It is all very worrying"[11].

The **Medical and Dental Act 2004** also provides:

29.4e Failure to obtain the informed consent of the patient before proceeding on any surgical procedure or course of treatment, when such consent, was necessary.

29.4f Making a mistake in treatment; e.g. amputation of the wrong limb, carelessness that results in the termination of a pregnancy, prescribing the wrong drug, or dosage in error for a correctly diagnosed ailment, etc.

29.4g Failure to refer, or transfer a patient in good time, when such a referral or transfer was necessary.

29.4h Failure to do anything that ought reasonably to have been done under any circumstance for the good of the patient.

With respect to 29.4h, see the case of **ABUBAKAR V JOSEPH (2008) 13 NWLR (PART 1104) 307 at 342 A-D per NIKI-TOBI JSC of blessed memory**

"In order to establish negligence, one pertinent question arises for consideration and it is whether as between the alleged wrong doer and the person who has suffered damage, there is a sufficient relationship of proximity or neighbourhood such that in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter.

The burden of proof of negligence falls on the plaintiff who alleges negligence. This is because negligence is a question of fact, and it is the duty of he who asserts to prove it. Failure to prove particulars of negligence pleaded will be fatal to the case of the plaintiff. In cases of motor accidents, the test to be applied in determining who was negligent is to look for the person whose negligence, substantially caused the accident by determining whether or not that person could have avoided the collision by the exercise of reasonable care. See Alhaji Otaru and Sons Limited v. Idris (1999) 6 NWLR (Pt.606) 330"

[11] HATCHER V BLACK & OTHERS (n.11).

29.4i Failure to see a patient as often as his medical condition warrants or to make appropriate comments in the case notes of the practitioner's observations and prescribed treatment during such visits. It also includes failure to communicate with the patient or with his relatives as may be necessary with regards to any developments, progress or prognosis in the patient's condition."

DISCIPLINARY ACTION AGAINST A MEDICAL/DENTAL PRACTITIONER

Section 15 of the **Medical And Dental Practitioners Act Cap M8 LFN 2004**[12] provides for the establishment of MEDICAL AND DENTAL PRACTITIONERS DISCIPLINARY TRIBUNAL otherwise known as the (DISCIPLINARY TRIBUNAL) which is responsible for the hearing and determination of any case of misconduct negligence or infamous conduct of a doctor referred to it by Medical and Dental Practitioners investigation panel also known as "the Panel" established under section 15(3) of the **Medical and Dental Practitioners Act 2004** which Panel is charged with conduct of preliminary investigation into any case alleging that a person registered as a Medical Practitioner or Dental Surgeon has misbehaved in his capacity as a Medical Practitioner or Dental Surgeon or for any other reason be subject of proceedings before the Disciplinary Tribunal.

Paragraph 2 (1) and (2) of second schedule to the **Medical and Dental Practitioners Act** vest power in and enables the Hon Attorney-General of the Federation to make Rules as to the selection of Member of Disciplinary Tribunal for the purpose of any proceedings and procedure to be followed and rules of evidence to be observed in the proceedings before the Disciplinary Tribunal.

The Rules also provide for opportunity for fair hearing before the Disciplinary Tribunal and the procedures are put in place to comply with section 36 of the Constitution of Federal Republic of Nigeria 1999 as amended.

For the purpose of arriving at a just decision at the end of a proceeding or trial of a Medical or Dental Practitioner Paragraph 4(1) and (2) empower the Chief Justice of Nigeria to make provisions for Assessors to advise the Disciplinary Tribunal on question of law arising in proceedings before the Tribunal. The assessors are appointed by the Medical and Dental Council of Nigeria upon nomination by the Chief Justice. The Assessor shall be a Legal Practitioner of not less than seven years standing.

[12] Medical And Dental Practitioners Act 2004.

Rule 1 of the Medical and Dental Practitioners (DISCIPLINARY TRIBUNAL) RULES (S.I of 19/3/1993) stipulates that:

> **"In any case where in pursuance of section 15(3) of the Act, the Panel is of the opinion that a prima facie case is shown against a Medical practitioner or a dental surgeon the panel shall prepare a report of the case and formulate any appropriate charge or charges and forward them to the Registrar together with all the documents considered by the panel"**[13]

Thereafter it shall be the duty of the chairman of the Medical and Dental Practitioners Registration council of Nigeria to convene a meeting of the Tribunal as laid out in accordance with Rules of Medical and Dental Practitioners (Disciplinary Tribunal) Rules 1993.

The Tribunal put in place must therefore be constituted in such a way as to secure its independence and impartiality. The complainant and defendant are entitled to be represented by counsel of their choice before the Tribunal.

PARTIES TO PROCEEDINGS BEFORE THE TRIBUNAL

The parties to the proceedings are the chairman of the Panel, the Medical Practitioner or the Dental Surgeon whose conduct is the subject matter of the proceedings and the complainant.

PENALTIES OR SENTENCE

The penalties that could be meted upon erring Medical practitioner or Dental Surgeon are laid out in section 16 and 17 of the Medical and Dental Practitioners Act 2004.

It is crucial to state that all necessary documents in respect of the case referred to Disciplinary Tribunal and list of witness to be called must be afforded to the Accused or Defendant to enable him or her make his or her Defence before the Tribunal. In other words the constitutional provisions relating to fair hearing must be scrupulous adhered to or observed:

See the cases of:

1. DENLOYE v MEDICAL AND DENTA;L PRACTITIONERS DISCIPLINARY COMMITTEE (1968) ALL N.L.R 308 per ADEMOLA CJN.
2. ALAKIJA V MEDICAL COUNCIL DISCIPLINARY TRIBUNAL (1959) 4 FSC 59

[13] Medical And Dental Practitioners Act.

"…where the Court held that the two years' suspension of a medical practitioner was an infraction to the principle of natural justice as the registrar, who served as a prosecutor also participated in the deliberations of the Committee."

TRIBUNAL LACKS JURISDICTION TO TRY OFFENCES WITHIN JURISDICTION OF OTHER COURTS

The settled position of the law is that where the allegations made against a Medical Practitioner or Dental Surgeon borders on offences covered under the Criminal Code or Penal Code then the Tribunal will do well to refer such a case to the High Court or any relevant court that has jurisdiction on the criminal offences.

See the case of:

MEDICAL AND DENTAL PRACTITIONERS DISCIPLINARY TRIBUNAL V. DR JOHN EMEWULO NICHOLAS OKONKWO (2001) 7 NWLR (PART 711) 206 at 234 D-H to 236A-B per Ayoola JSC (of blessed memory)

"In Denloye's Case the defendant was tried by a tribunal on five counts of infamous conduct. In the first he was alleged to have neglected a patient who was seriously ill and for whose treatment he was responsible while several criminal offences covered by sections 82 and 89 of the Criminal Code were charged in the remaining four counts. He was found guilty and his name ordered to be removed from the medical register. On his appeal to the Supreme Court it was argued by his counsel, relying on section 22(2) of the 1963 Constitution, that it was not competent for the Tribunal to try offence chargeable under the Criminal Code. This court held that the allegation in the first count was not of such an offence.

However, in regard to the other counts which it found to have charged offences covered by the Criminal Code, it held that the Tribunal had no jurisdiction to try them. Its decision was not based on section 22(2) of the 1963 Constitution but on what it considered to be intendment of the Act. Ademola, CJN, delivering the judgment of the court said:

"Under the English Medical Act, 1956 charges of this nature which covered by the criminal law are not dealt with under the Act in the first instance but are left to the

courts. After convictions have been obtained in the courts disciplinary actions would follow. We have no doubt in our minds that this is the intention in this country as well. At p. 265 he said:

"In effect where the unprofessional conduct of the practitioner amounts to a crime it is a matter for the courts to deal with; and once the court has found a practitioner guilty of an offence, if it comes within the type of cases referred to in section 13(1)(b), then the Tribunal may proceed to deal with him under the Act." (Emphasis mine)

In Sofekun v. Akinyemi & 3 Ors. [1980] 5 -7 SC I and Garba v. Ors v. University of Maiduguri (1986) 1 NWLR (Pt. 18) 550, (1986] 1 NSCC 245 substantially the same conclusions were arrived at, albeit, by a slightly different route. This court decided in those cases the broad question of the jurisdiction of an administrative disciplinary tribunal to try allegation of a criminal nature on the basis of the exclusive judicial powers vested in the courts or tribunals established by law as provided in section 6(1) and (2), and section 33(1) and (4) of the 1979 Constitution. Constitutional provisions apart, it is clear that the Tribunal with which the present case is concerned is set up to try specified offences under the Act. It has no jurisdiction to try criminal offences at large. The function of the Tribunal, established under section 15 of the Act, is to consider and determine any case ; referred to it by the panel established under sub-section 3 of section 15 and any other case of which the tribunal has cognisance under the Act. The function of the Medical and Dental Practitioners Investigating Panel, so far as is relevant to this case, is to conduct, preliminary investigation into any case where it is alleged that a registered person has misbehaved in his capacity as a medical practitioner, or should for any other reason be the subject of proceedings before the tribunal.

Section 16(1) contains provisions for award of disciplinary measure after conviction of the practitioner for a criminal offence. Where infamous conduct cannot be established

without proving facts that would amount to an offence covered by the Criminal Code the Tribunal should yield to the criminal courts established for the trial of such offence. To hold otherwise may lead to a conflict of verdicts, where a Tribunal had first tried the matter and found the practitioner not guilty of infamous conduct, while on the same set of facts a criminal court finds him guilty of a criminal offence and convicts him; or vice versa. That may lead to the incongruous situation of the Tribunal having to revisit the matter and act pursuant to section 16 in case of a conviction by the criminal court. Where the criminal court acquits a practitioner who has been found guilty by the Tribunal and penalised, some complications may arise. The recent English case of Law Society v. Gilbert [The Times; Jan. 12, 2001] affords a comparison in approach. In that case a solicitor who had admitted conduct unbefitting a solicitor before a disciplinary tribunal and has been suspended from practice for three years, was subsequently convicted of offences of dishonesty on the basis essentially of the same facts. The Law Society then brought a second set of disciplinary proceedings based on that conviction. It was held by the English Queen's Bench Divisional Court that the second set of disciplinary proceedings was not an abuse of process. As reported, Lord Justice Woolf, C.J., said

> **"Disciplinary proceedings brought by the Law Society in relation to its members were brought primarily not with the intention of imposing punishment on the solicitor in question but with the important purpose of maintaining the standards of the profession.**
>
> **The important feature of the present case was that when the first Tribunal considered the matter, it did not know that Mr. Gilbert would subsequently be convicted. That was not a matter which was before the first tribunal. It would have been open to the Law Society to await the outcome of any criminal proceedings before commencing the first set of disciplinary proceedings. However, such a course had real disadvantages. The Law Society would**

have had to defer for may be a substantial period the bringing of disciplinary proceedings. That could have meant that the public was put to risk."

Notwithstanding the case of Law Society v. Gilbert to which reference has just been made merely for the purpose of comparison of approach, our law stands as decided in Denloye's case. However, it may well be worthwhile to consider, should an appropriate occasion arise, how best to deal with the problems that may arise from the inability of the disciplinary body to enforce discipline with the necessary dispatch in the face of the slowness of our criminal justice system. Be that as it may, the Tribunal would have had no jurisdiction to try count 1 if that count had charged a criminal offence covered by the Criminal Code."

RIGHT OF APPEAL

A convicted medical or dental practitioner, person or complainant can appeal the decision of Disciplinary Tribunal to the Court of Appeal within 28 days from the date of service on him of the notice of the direction, as to penalty or sentence to be suffered by the convicted Medical or Dental Practitioner. See also Section 240 of the **Constitution of the Federal Republic of Nigeria 1999 (as amended)**.

"Subject to the provisions of this Constitution, the Court of Appeal shall have jurisdiction to the exclusion of any other court of law in Nigeria, to hear and determine appeals from the Federal High Court, the High Court of the Federation Capital Territory, Abuja, High Court of a state, Sharia Court of Appeal of the Federal Capital Territory, Abuja, Sharia Court of Appeal of a state, Customary Court of Appeal of a state and from decisions of a court martial or other tribunals as may be prescribed by an Act of the National Assembly."[14]

[14] Constitution of the Federal Republic of Nigeria (as amended) 1999.

CIVIL LIABILITY

Negligence is the underpinning basis for civil liability where a Medical Practitioner or Dental Surgeon fails to exhibit any competence or proficient ability in his professional field while treating his patient. It is a breach of general duty of care and failure on the part of the Medical Practitioner to take necessary precaution in administering treatment on his patient. However a Medical and Dental Practitioner will not be liable for negligence or malpractice where he takes all necessary precaution expected of a Medical or Dental Surgeon.

Where having regard to all the circumstance he exhibits skills expected of a person in his position or the same profession would deploy to treat a patient, he cannot be said to be guilty of negligence or malpractice. Where the action cannot be said to be reckless or irresponsible the claimant or the plaintiff's case is bound to fail.

The burden or onus of proof is on the claimant complaining of Medical negligence to prove or establish

a. The existence of a duty of care
b. Failure to exercise such duty of care by the Medical Practitioner
c. Resultant injury to the patient is a result of the breach of duty and
d. Causation or link between the acts of negligence and damage suffered.[15]

WHETHER THE EMPLOYER (MASTER) IS VICARIOUSLY LIABLE WITH THE MEDICAL PRACTITIONER (THE SERVANT)

The claimant can sue the employer and the medical practitioner - employee jointly and severally for medical malpractice and negligence and claim damages. See the cases of:

1. **UNVERSITY OF ILORIN TEACHING HOSPITAL VS DR DELE ABEGUNDE (for himself and family of late Chief Ernest Omotade Abegunde (2015) 3 NWLR (PART 1447) 421**. The University was sued for negligent treatment. The deceased was admitted for drubbing urine and slurred speech. That the deceased was also diabetic and hypertensive and that Appellant claimed it had control over all the ailments. The Respondent won at the lower court but the appeal of the Appellant to the Court of Appeal was allowed in that the ingredient of negligence were unproved

[15] Selbyen Oluokun, 'An Analysis of Medical Negligence in Nigeria: Challenges and Way Forward' (2024) 11 Journal of Commercial and Property Law 131 <https://journals.unizik.edu.ng/jcpl/article/view/3905> accessed 15 December 2024.

and that the facts pleaded were not substantiated. At page 454 B-H to 455 A-D, My Lord OGBUINYA JCA now JSC said:

> **"…the foregoing forensic analyse find deep: anchorage in the case of Ojo v. Gharoro (2006) 10 NWLR (Pt. 987) 173. Therein, a needle got broken in the abdomen of the appellant during surgical operation. It was held that the respondents exercised their best medical skills and so not negligent. To fortify the decision, the apex court borrowed the illuminating and incisive words of the great jurist, Lord Denning, in his book, The Discipline of Law, pages 237, 242 and 243 wherein he opined:**
>
> **"A medical man, for instance, should not be found guilty of negligence unless he has done something of which his colleagues would say: "He really did make a mistake there. He ought not to have done it' ...but in a hospital, when a person who is ill goes in for treatment, there is always some risk, no matter what care is used. Every surgical operation involves risks. It would be wrong, and, indeed, bad law, to say that simply 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 for an action for negligence against a doctor is for him like unto a dagger. His professional reputation as severely as a dagger can his body. You must not therefore, find him negligent simply because something happens to go wrong ..."**
>
> **You should only find him guilty of negligence when he falls short of the standard of a reasonably skilful medical man, in short, when he is deserving of censure. This decision, seriously, bears out my viewpoints in the case in hand. The appellant, qua its staff, applied the best medical skills in the management of the deceased. A reasonable man is a person who acts sensibly, does things diligently and takes proper, but not excessive, precautions. No medical doctor can**

conclude that the functionaries of the appellant failed/neglected to do what a reasonable man, under those circumstances, would do in the treatment of the deceased.

In sum, I hold that the appellant displayed the required standard of a reasonably skilful medical man in the management of the deceased. In the aggregate, it is my view, after due consultation with the law, that the appellant did not breach the duty of care it owed the deceased during the period that he patronized it for his medical treatment. Simply put, the respondent failed to fulfil the second ingredient of negligence already outlined at the dawn of this issue.

It admits of no argument that the second ingredient is the keystone for the third ingredient of negligence, occurrence of damage.

It stems from that, that the respondent has not, de jure, met the third ingredient as it is impossible for him to incur injury without the appellant's infraction of its duty of care. All in all, I return a negative answer to the question posed earlier, that is, the respondent failed, woefully, and on the preponderance of evidence to establish medical negligence against the appellant."

2. **ABV TRANSPORT CO. LTD V MISS BUNMI OMOTOYE (2019) 14 NWLR (PART 1692) 197 at 211C-F per ABBA AJI, JSC who said**

"…It is the law therefore that in an action for negligence, the plaintiff must prove the following essential elements:

(a) The existence of a duty of care owed to the plaintiff by the defendant.

(b) Breach of that duty of care by the defendant.

(c) Damages suffered by the plaintiff as a result of the breach by the defendant of that duty of care.

See Edok-Eter Mandilas Lid. v. Ale (1985) 3 NWLR (Pt. 11) 43, Okeowo v. Chief Sanyaolu (1986) 2 NWLR (Pt. 23) 471, Agbonmagbe Bank v. General Manager G.B. Ollivant Ltd. (1961) 1 All NLR 116; (1961) 2 SCNLR 317, Mercantile Bank of Nigeria Ltd. v. Abusomwan (1986) 2 NWLR (Pt. 22) 270. In order to establish negligence, one pertinent question arises

for consideration and it is whether as between the alleged wrong doer and the person who has suffered damage, there is a sufficient relationship of proximity or neighborhood such that in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter. By the summations above, it cannot be argued that the respondent has proved against the appellant the existence of a duty of care owed to her, breach of that duty of care by the appellant and damages suffered by the respondent as a result of the breach by the appellant of that duty of care."

It can thus be seen that a claimant in order to succeed in action for negligence by a Medical Doctor cannot make a blanket allegation without given full particulars on the elements of negligent and proves them in accordance with the law. The duty of care must be proved to exist. He must also prove the standard of care prescribed by the law. Above all he must also prove that whatever damages or injury that he suffered is as a result of the breach of duty of care the Defendant owed him.

See: MISS FELICIA OSAGEDE OJO VS DR GHARORO & ORS (2006) 10 NWLR (PART 987) 173, where the Appellant did not call vital witnesses to establish that the Doctor who operated her was negligent in allowing a needle used in performing operation on her which got broken in her womb was a negligent action necessitating a second operation on her. Her reliance on Res Ipsa loquitur failed and the Courts held that she did not establish case of negligence against the Doctor. At page 216 C-H to 217 A-D NIKI-TOBI JSC found:

"The doctrine of res Ipsa loquitur is premised or predicated on the mere fact of the event happening, which is based on two rebuttable presumptions and I repeat two rebuttable presumptions, viz: (1) That the event happened as a result of a duty of care somebody owes his neighbour. (b) And that somebody is the defendant.

Negligence and in the context of this case, illustrating to the specific tort of res Ipsa loquitur, like most other torts, is a negative tort, as far as the defendant is concerned. The law therefore places a burden on the plaintiff to prove that the defendant was negligent, and in the circumstances of this case, the act of leaving the piece or pieces of needle in the

abdomen of the appellant (which qualified as the happening event) says it all. In the proof of the act, the plaintiff must satisfy the twin but alternative standards of proof: (a) balance of probability and, (b) preponderance of evidence. In either of these standards, the plaintiff must come out clearly with cogent evidence as to the specific act or acts of the defendant which resulted in the negligence and not merely an agglomeration of act or acts lacking specificity. For res Ipsa loquitur to apply, the event which gave rise to the negligence must tell its own story and it must invariably be a clear and unambiguous story of lack of duty of care. From the totality of the case before the trial court, I believe the evidence of the 1st respondent that "the needle in this case got broken accidentally and proper care was taken to locate the pieces." In any human situation, accidents are bound to happen and when they happen they must be accommodated by humanity - the quality of being humane or human. This is because no human situation is perfect. The only perfect situation is the situation created by the Almighty God. It has no accident at all. I am satisfied from the evidence that all efforts to locate the piece or pieces of the needle proved abortive, despite the application of the best professional skills by the respondents. In my humble view, the respondents did their best, and their best in my view, was the best for the medical profession in this country in terms of case or patient management.

I see in this case a situation where the appellant dumped on the trial court the plea of res Ipsa loquitur qua tort of negligence, without more, to harass the respondents who made available to her all their professional skills to cure her. Let me end this judgment with the words of that great Judge, Lord Denning, in his sub-chapter titled "Doctors at Law in Part Six on Negligence in his book: The Discipline of Law, pages 237, 242 and 243:

"A medical man, for instance, should not be found guilty of negligence unless he has done something of which his colleagues would say: "He really did make a mistake there.

He ought not to have done it' ..but in a hospital, when a person who is ill goes in for treatment, there is always some risk, no matter what care is used. Every surgical operation involves risks. It would be wrong, and, indeed, bad law, to say that simply 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 for ever looking over his shoulder to see if someone was coming up with a dagger for an action for negligence against a doctor is for him like unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body. You must not therefore, find him negligent simply because something happens to go wrong... You should only find him guilty of negligence when he falls short of the standard of a reasonably skilful medical man, in short, when he is deserving of censure."

One sees the above fairly liberal stand in some of his judgments. If Lord Denning, known for his radical activism can take such a position, then the legal position should be so, particularly in this appeal where the respondents clearly rebutted the presumption of negligence. While I am in sympathy with the position of the appellant, my sentiments will not go far to give her judgment by allowing this appeal. After all, it is good law that sentiments have no place in the judicial process, particularly when the sentiments are against the law. The Judge that I am, I must bow to the law, and I so bow."

It would appear that the obstacle in the way of the claimant most of the time is refusal by some Doctors who would not want to testify against a professional colleague and so the desire expert evidence needed may be an illusory.
The Doctor was adjudge not liable for negligence.

WHERE PATIENT OBJECTS TO TREATMENT EITHER AS OF RIGHT OR ON RELIGIOUS GROUND

SECTION 37 AND 38 OF THE CONSTITUTION OF NIGERIA 1999 are as follows:

> **"37 The privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby guaranteed and protected.**
>
> **38 (1) Every person shall be entitled to freedom of thought, conscience and religion, including freedom to change his religion or belief, and freedom (either alone or in community with others, and in public or in private) to manifest and propagate his religion or belief in worship, teaching, practice and observance.**
>
> **(2) No person attending any place of education shall be required to receive religious instruction or to take part in or attend any religious ceremony or observance if such instruction ceremony or observance relates to a religion other than his own, or religion not approved by his parent or guardian.**
>
> **(3) No religious community or denomination shall be prevented from providing religious instruction for pupils of that community or denomination in any place of education maintained wholly by that community or denomination.**
>
> **(4) Nothing in this section shall entitle any person to form, take part in the activity or be a member of a secret society."**[16]

The above provisions of the Constitution give the right to private and family life and to freedom of thought conscience and religion to everyone in the country. Thus a patient may refuse Medical procedure or treatment for personal reasons, religious beliefs or for no reason at all. The Constitution recognised the right of an adult to do what pleases him or her to his/her welfare health and social wellbeing in as much as he or she does not infringe on other people's rights and obligation.

Where a person on account of the enumerated reasons opt out of treatment or refuses to be transfused with blood or informs the Doctor he would not take blood because he or she is a Jehovah's witness such a Doctor

[16] Constitution of the Federal Republic of Nigeria (as amended).

or Dental medical practitioner will do well to be properly guided by all laws particularly the Code of Medical Ethics relevant to taking decision whether or not to treat or continue to give medical treatment to such a Patient particularly an adult. It is better for the Doctor to accede to the wish of a patient but must make sure that all relevant documentations are made and proper records kept so that the Doctor will save himself the trouble of being accused and found guilty of medical malpractice or negligence. No one can justifiably blame a Doctor for playing safe and in respecting the wishes and rights of patients which are guaranteed in our constitution. Rule 22 of the Code of Medical Ethics provide:

> **" Management of Patients who Refuse Blood Transfusion**
> **22.1 a. (i) At the moment of induction, all qualified doctors subscribe to the Hippocratic Oath (as modified by the Declaration of Geneva part of which reads thus: * will not permit consideration of religion, nationality, race, party, politics or social standing to intervene between my duty and my patient. in clear terms, whatever the religious orientation of the practitioner or the patient. it must not determine the quality of treatment so offered (ii) Often times, this commitment has led many practitioners into conflict with patients and relatives who refuse blood transfusion on religious grounds, and in some cases may result to litigation. The law does not permit the doctor to give any treatment against the patient's wishes. (iii) However, practitioners should be aware that society, and indeed the law, recognises the individual's right to accept or refuse medical treatment. The Jehovah's Witnesses* refusal of transfusion with blood and blood products is perhaps the most commonly encountered decline of clinical treatment that might be essential to save life, especially in emergencies.**
> **22.1b (i) In all situations where blood transfusion might be necessary, it is essential to ask patients whether they object to blood transfusion and to record such views in the case notes. It is important to establish the views held by each Jehovah's Witness patient as certain forms of transfusion, such as blood salvage techniques, haemodilution,**

haemodialysis, the use of fractions such as albumin, immune globulins and clotting factors may be acceptable. Pre-donation is not usually acceptable to Jehovah's Witnesses. The acceptance, and particularly the rejection of essential treatment should be recorded and witnessed, There are reasonable strategies that can be adopted for patients who refuse blood transfusion. In the first place, surgeons should observe the principle of doing surgery with the minimum blood loss. Post-operative bleeding must be surgically stopped if significant enough to threaten life, Intravenous administration of crystalloids and other non-blood volume expanders should always be available in hospitals and clinics. (ii). In non-emergency situations, the practitioner should decide if he is willing to accept the limitations in management and, if so, offer optimal care; if not, the practitioner may decline care and refer such patients for further opinion or to other health care centre that might be willing to handle such cases.

22.1c The Unconscious Patient Some religious sects may carry cards (advance directives) containing treatment instructions that legally prohibit blood transfusion. Their clothing should be searched for such cards. Even if accompanying relatives present such cards, clinicians should convince themselves that such cards truly belong to the patient before them. In the absence of such cards, the priority of the practitioner in an emergency situation is to first save life by any available means. I relatives present a persistent impediment and the clinical condition permits it, the doctor should obtain a court permit to surmount it. The practitioner should be wary of acting on verbal instructions from relatives of unconscious patients."

What I believe should be the proper guidance and procedure can be found in the case of **MEDICAL AND DENTAL PRACTITIONERS DISCIPLINARY TRIBUNAL VS DR JOHN EMEWULU NICHOLAS OKONKWO (2001) 7 NWLR (PART 711) 206 at 243 F-H to 245 A-C per My Noble Lord AYOOLA, JSC (of blessed memory)** who said:

"Rule 5 does not enjoin the practitioner to refer a patient who has refused medical treatment for religious reasons to another doctor or health institutions. The situation envisaged in rule 5 is one in which an examination or treatment is beyond that practitioner's capacity. Where a patient refuses medical treatment for religious reasons the professional capacity of the practitioner is not called into question by that fact alone. In these circumstances, it is clear that the Court of Appeal was right when it concluded that the measures which the Tribunal held the respondent should have adopted had not been part of the rules or code of conduct. It is evident that the Rules of Professional Conduct which the Tribunal appeared to have relied heavily on did not offer much guidance in answering the question which the Tribunal considered central to the case, namely: what course of action should a practitioner who has been denied informed consent to carry out a medical life saving measure take?

Religious objection to medical treatment: limit of practitioner's responsibility

The scope and limit of the duty of a practitioner faced with a patient's refusal to give informed consent of life saving medical treatment cannot be considered in isolation of the right of the patient. Although, there is a dearth of local authorities in this area of our law, there are ample provisions of our Constitution which show the basis on which the court should proceed in these matters. It is expedient at the outset to recognise that a consideration of a religious objection to medical treatment involves a balancing of several interests, namely: the constitutionally protected right of the individual, state interest in public health, safety and welfare of society; and, the interest of the medical profession in preserving the integrity of medical ethics and, thereby, its own collective reputation. To give undue weight to one of these other interests over the rights of the competent adult patient may constitute a threat to liberty of the individual,

unless legally recognised circumstances justify that weight should be ascribed to one over the others.

> Where, for instance, the health and safety of society is under threat, for instance in an epidemic, public health and safety may be given a higher weight than the individual's human rights. Where, however, the direct consequence of a decision not to submit to medical treatment is limited to the competent adult patient alone, no injustice can be occasioned in giving individual right primacy. In my judgment, any rule of ethics or professional conduct that ignores the need to balance these interests or that gives undue weight to any of them without regard to individual circumstances will be out of touch with reality and may lead to unjust consequences. This, in my understanding, was what Nzeako, JCA, tried to emphasise when she stated thus:
>
> "Everything put together, it does appear that the code of ethics which requires a medical practitioner to 'always take measures that will lead to preservation of life failed to pin down on the conflict between the right of a patient to decide on what medical measures to agree to and the doctor's code of ethics."

The patient's constitutional right to object to medical treatment or, particularly, as in this case, to blood transfusion on religious grounds is founded on fundamental rights protected by the 1979 Constitution as follows: (i) right to privacy: section 34; (ii) right to freedom of thought, conscience and religion: section 35. All these F are preserved in sections 37 and 38 of the 1999 Constitution respectively. The right to privacy implies a right to protect one's thought, conscience or religious belief and practice from coercive and unjustified intrusion; and, one's body from unauthorised invasion. The right to freedom of thought, conscience or religion implies a right not to be prevented, without lawful justification, from choosing the course of one's life, fashioned on what one believes in, and a right not to be coerced into acting contrary to one's religious belief.

The limits of these freedoms, as in all cases, are where they impinge on the rights of others or where they put the welfare of society or public health in jeopardy. The sum total of the rights of privacy and of freedom of thought, conscience or religion which an individual has, put in a nutshell, is that an individual should be left alone to choose a course for his life, unless a clear and compelling overriding state interest justifies the contrary. Law's role is to ensure the fullness of liberty when there is no danger to public interest. Ensuring liberty of conscience and freedom of religion is an important component of that fullness. The courts are the institution society has agreed to invest with the responsibility of balancing conflicting interests in a way as to ensure the fullness of liberty without destroying the existence and stability of society itself. It will be asking too much of a medical practitioner to expect him to assume this awesome responsibility in the privacy of his clinic or surgery, unaided by materials that are available to the courts or, even, by his training. This is why, if a decision to override the decision of an competent patient not to submit to blood transfusion or medical treatment on religious grounds, is to be taken on the grounds of public interest or recognised interest of others, such as dependent minor children, it is to be taken by the courts. It is to the credit of the Tribunal in this case that it acknowledged the right of the individual to hold his religious belief and that it also accepted that a practitioner should respect the religious beliefs of others. Its decision in the case, how-ever, progressed into error when it deviated from the correct path into ignoring the concomitants of the right of the patient to reject medical treatment or blood transfusion on religious grounds, and concluded that the respondent was guilty of infamous conduct "for holding onto the patient knowing fully well that the correct treatment cannot be given in the face of failure to obtain consent."

The lacuna in the old Rules of Professional conduct in Medical profession has now been cured by the provisions of Rule 22 of The Code Of Medical Ethics In Nigeria, 2008.

RIGHT OF A MINOR TO MEDICAL TREATMENT

However where a child patient is involved, the situation may be different. As a minor or young person, such a patient may not be able to take decision on his or her own as to which option is open to him or her before or in the course of medical procedure or treatment.

What about a child who is in an urgent or dire need for blood transfusions or other medical procedure that would require taking of his/her blood to carry out various tests for a proper diagnosis? where the parent or guardian of such a child refuses treatment or medical procedure stated, then, the Doctor can report to the Police or other appropriate authority or agency of government so that necessary or appropriate steps could be taken to save or protect the life of such a child against religious view or belief of his parent or guardian not to submit the child for blood transfusion or other related procedure in Hospital or Health establishments. See **TEGA ESABUNOR & ANOR VS DR TUNDE FAWEYA & ORS (2019) 7NWLR (PART 1671) 316 at 340 A-F per OLABODE RHODES-VIVOUR JSC** who said:

> **"Dr Faweya, the 1st respondent, examined him and found that the child was suffering from severe infection and anemia (lack of blood). Antibiotics were administered on the child to help fight the infection. In the morning of the next day, Dr Faweya observed that the child was in very bad shape with poor colour; was convulsing and had poor breathing. The child was immediately placed on oxygen therapy. According to Dr. Faweya it became increasingly obvious to him that the child desperately needed a blood transfusion to remain alive.**
>
> **The child's mother bluntly refused blood transfusion for her child. She made it clear that because of her religious beliefs, being a member of the Jehovah Witness sect she cannot consent to her child receiving blood. Acts 15:29 in the Bible says in part: Keep abstaining from blood...**
>
> **Jehovah Witnesses believe that the Bible commands that they do not ingest blood included through transfusion.**
>
> **<u>This issue involves a convergence of religion, medicine and law. It is long settled that an adult who is conscious and in full control of his mental capacity, and of sound mind has the right to either accept or refuse blood (medical treatment).</u>**

The hospital has no choice but to respect their patients wishes. All adults have that liberty of choice. This freedom has been exercised in accordance with the rule of law (see section 45(1) (b) of the Constitution).All adults have the inalienable right to make any choice they may decide to make and to assume the consequences. When it involves a child, different considerations apply and this is so because a child is incapable of making decisions for himself and the law is duty bound to protect such a person from abuse of his rights as he may grow up and disregard those religious beliefs. It makes no difference if the decision to deny him blood transfusion is made by his parents. See M. D. P. D. I. v. Okonkwo (2001) 7 NWLR (Pt.711) p.206. When a competent parent or one in loco parents refuses blood transfusion or medical treatment for her child on religious grounds, the court should step in, consider the baby's welfare, i.e. saving the life and the best interest of the child, before a decision is taken. These considerations outweigh religious beliefs of the Jehovah Witness sect.The decision should be to allow the administration of blood transfusion especially in life threatening situations."

At page 342 B-C His Lordship of Supreme Court said :

" the order of the Chief Magistrate (1st respondent) that learned counsel for the appellants wants quashed by the writ of certiorari reads: The medical authorities of the clinic of Chevron Nigeria Limited, Lekki Peninsula, Lagos, are hereby authorised to do all and anything necessary for the protection of the life and health of the child, TEGA ESABUNOR. In compliance with the above, Dr. Faweya administered blood transfusion on the 1st appellant."

At the same page 342G-H to page 343 A His Lordship also had this to say:

"The case of the appellants is that the 1st appellant was administered blood transfusion without authorization of his mother (the 2nd appellant). It is the trespass of transfusion on the body of the 1st appellant without consent that the appellants are challenging. Trespass in this context is an unlawful entry or invasion by Dr. Faweya on the body of the

1st appellant. The general rule is that damages awarded by a trial court is based on evidence before the court and where there is no evidence to support a claim for damages, the claim should be dismissed. Ingesting the child with blood was a lawful act backed by a court order. Dr. Faweya complied with the court order to save the life of the child. There was no evidence and there could be none to justify the award of damages for a lawful act. The appellants are not entitled to damages."

RIGHT OF A DOCTOR TO WITHDRAW HIS SERVICES TO HIS PATIENT

There are occasions when a patient's health will be slow in responding to treatment either at Government Hospitals or Private Hospital or clinic. The patient and members of his family may become worried and believe that perhaps the Medical or Dental Practitioners is incompetent or has been giving the patient wrong treatment. This may be due to wrong diagnosis.

The Patient may become agitated and even feels the Doctor was or is showing less concern to the progress or improvement in his health in order to make more money.

Whenever there is lack of trust between the Doctor and his patient it becomes imperative for the two sides to reevaluate the situation. The Doctor may in his discretion advise the patient to try another Hospital or healthcare or by mutual agreement specialist may be invited to evaluate the patient's condition.

The Patient or guardian may decide on their own to ask for discharge so they could go elsewhere. Both parties have right to withdraw and can mutually agree to disengage or withdraw such service as the case may be. The doctor must however not withdraw his services to the detriment of the patient or breach of conditions for withdrawal of service as laid out in Rule 45 of the Code of Medical Ethics which providers

"Right to Withdraw Service (Strike)

Once a doctor assumes the responsibility to care for a patient, his right to withdraw such a service would arise only for a good cause. Even the desire or consent of the patient is not always sufficient. The doctor should not relinquish the management of a patient to the detriment of the patient. When he has reason for doing so on grounds of honour or

self-respect, he should hand over the patient properly to another medical practitioner for further management.

If the patient insists upon an unjust or immoral course in the process of his treatment, or if he deliberately disregards an agreement, or obligation as to fees or expenses, the doctor may be warranted in withdrawing on due notice to the patient, allowing him time to employ another doctor. Other instances as they arise may justify withdrawal. It would be permissible for a doctor to withdraw his services ("industrial action or strike") in pursuit of his rights under the Labour Laws of the Federal Republic of Nigeria, provided that any doctor wishing to take that course of action must have made satisfactory arrangements for the continuing care of his patients and must have given adequate notice of his intention to these patients and to the hospital authorities. In embarking on withdrawal of services under any circumstance, a doctor must conduct himself in such a manner as to avoid suffering and loss of life for the helpless patients, such as children and accident victims, who had not in any way contributed to the dissatisfaction which has made the withdrawal of service necessary. Upon withdrawing from the management of a case after a fee has been paid, the doctor should refund such part of the fee as has not been clearly earned."

One wonders whether the Doctors are following the crucial conditions included in the above Rule because whenever there is strike the entire or most of the Government Hospitals many of the time are deserted and patients and their families would be constrained to take them to private Healthcare for treatment. The doctor must be circumspect and be properly guided by ethics of the profession and operate within the confines of what the law permit.

I believe that the constitution of the Federal Republic of Nigeria 1999 as amended, all the Acts referred to particularly

1. The Medical and Dental Practitioners Act CAP M8, LFN 2004;
2. The Nursing and Midwifery (Registration, etc.) Act 1979;
3. The National Health Act 2014:
4. The Code of Medical Ethics in Nigeria (pursuant to section 1(2) (c) of CAP M8;

5. The Constitution of the Federal Republic of Nigeria 1999 (As Amended);
6. Th Code of Medical Ethics in Nigeria
7. The Compulsory Treatment and Care for Victims of Gunshot Act 2017; and Decisions of our Appellate courts have all stated in unambiguous terms the bounden duties and obligations of Medical and Dental Practitioners in Nigeria to their patients and all persons seeking health and social wellbeing in Hospital and other healthcare facilities.

The rights of the Doctor and their patients are also protected under various legislations and enactments all of which give assurances that both the Doctors and patients have rights and obligations while seeking for good health of body and minds under the hands and supervision of Doctors and healthcare providers.

It is also correct to state that all the various legislations put in place have manifestly put medical malpractice and negligence on the decline.

I am grateful for your kind attention and patience.

Hon. Justice Peter Olabisi Ige, JCA (Rtd)
16th December 2024

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