PROFESSIONAL MEDICAL NEGLIGENCE IN NIGERIA

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Introduction

Generally, professional medical negligence or malpractice has been on the increase and needs to be addressed in terms of the attitude of law towards medical practice for the protection of the patient to make the physician liable as well as to secure punitive punishment for any medical practitioner who through carelessness causes harm to a patient. Moreover there is the need to caution medical practitioners who have sent many patients to their untimely graves in the course of their professional duties. It would in addition aid to restore people's confidence in the medical profession.

Increasingly, there is the need for patients to be protected from medical practitioners who no longer see their professional calling principally as that of saving lives but as that of making money. The need for the protection of patients is not new. In advanced countries, precaution has been taken through legislation and through increased reliance on court action both of which ensure that negligent medical practitioners are made to pay damages to affected patients.

The crucial question then is, how to determine the extent to which medical decisions should be the object of legal scrutiny and control. At one extreme, there are those who hold that the medical profession should be left to regulate itself and that it alone should decide what is an acceptable conduct.

According to this view, intervention by the law is too blunt a way of tackling the delicate ethical dilemmas, which doctors have to face. The individual conscience guided by personal experience and the ethical code of the profession as well as the need to confront and resolve the day to day ethnical issue of medical practice. In addition, medical practitioners would have to grapple with lack of resources considering the economic problems facing Nigeria today and other factors that may hinder good medical practice.

The contrary view, frequently expressed just as firmly denies that there is any reason why doctors alone should regulate the relationship with patients. According to this proposition, the aspect of reserving to the medical profession the right to decide on issues of life and death is an improper derogation from an area of legitimate public concern. The law is designed to vindicate individual rights and to ensure that certain basic rules of social conduct are observed. The medical profession therefore like any other professions has become increasingly open to legal scrutiny.[1]

It is important at the outset to explain such key terms as medical practitioner, the law of negligence and medical negligence.

Who Is a Medical Practitioner

It is proper to study the structures and what it takes to qualify as a medical practitioner. The Medical Practitioner's Act 1963 of Nigeria was enacted in 1963 as Act No 3. The purpose of the Act was to regulate the practice of the medical and dental profession. The council's functions include:

[1] Ogiamien, T B E, "Medical Practice and the Law," *Nigerian Observer,* February 20, 1994, p 5.

1. Determining what standard of knowledge and skill are to be attained by persons seeking to become members of the medical or dental profession and raising those standards from time to time as the circumstance may permit.
2. Securing in accordance with the provision of the Act the establishment and maintenance of register of persons entitled to practice as member of the medical and dental profession and the publication from time to time of lists of those persons
3. Performing other functions conferred on the council by the Act that includes the establishment of a disciplinary tribunal and an investigation panel.

For, persons who are seeking to be registered as medical or dental practitioners and who have applied in the specified manner to be so registered need the following requirements:

i. Registration of consultants: those who are entitled to be registered as consultants are those qualified in specialised branches of medicine, surgery, midwifery or dental surgery. Such persons must have the necessary post qualification experience as may be prescribed by the rules made by the council.
ii. Separate registers are maintained for medical practitioners and for dental surgeons. The register consists of three parts. The first part is in respect of fully registered persons while the second part is in respect of provisionally registered persons and the third part is in respect of temporarily registered persons.

Those who have undergone practical pre-registration training as House officers in a recognised hospital for a period of one year qualify for full registration. The pre-registration training is essentially rotatory and embraces the different branches of medicine such as general medicine, surgery, paediatrics as well as obstetrics and gynaecology. Applicants for full registration are expected to submit, among other things, four certificates of satisfactory performance during the internship year. Such certificates must be duly signed by the various consultants under whose supervision the applicant worked.

Provisional registration is for newly qualified doctor who have passed the final qualifying examinations conducted by recognized institutions either in Nigeria or abroad. Temporary registration is designed for aliens who hold qualifications from institutions recognised for medical training by the Nigerian Medical Council. Such applicants are expected to produce evidence of employment for a specified period in a hospital or, as the case may be any other institutions approved for the practice of medicine by the Nigerian Medical Council. Aliens as well as Nigerians, who have qualified as doctors in recognized universities outside Nigeria are expected to pass the Nigerian Medical Council Assessment Examination before registration.

It is the act of registration and not the medical qualification that confers on the practitioner the legal right to practice medicine. This emphasizes the need for registration with the Nigerian Medical Council before engaging in any form of medical practice.

Medical Ethics

In many developing countries of the world, it is not unusual to go through a medical school without acquiring a sound knowledge of the subject of medical ethics. Over the years, there have been great advances and progressively widening scope in the complexities of medical problems, to the extent that in many areas there are no clear cut guidelines for the practitioner.

Nigeria needs to emphasis the subject of medical ethics, in medical schools, to acquaint the intending medical practitioner with his primary duty as a medical doctor in the course of his professional practice.

The word “ethics” is derived from the Greek word “ethos” that means customs and habits. The word relates to the precepts that deal with the nature and grounds of moral obligation and habit. Ethics is that science of knowledge, which deals with the nature, and grounds of moral obligations, distinguishing what is right from what is wrong.

Hippocrates recognized the need for a code of conduct for practitioners of the act of healing and laid down a statement or code of medical ethics. It runs as follows:

> I swear by Apollo Physican and Ascalepius Hygiea and Panuceia and all the gods and goddesses, making them my witness that I will fulfill according to my ability and judgement this oath and this covenant. To hold him who has taught me this art as equal to my parents and to live in partnership with him and if he is in need of money to give him a share of mine and to regard his offspring as equal to by brothers in male lineage and to teach them this art if they desire to learn it without fee and covenant – to give a share of precepts and oral instruction and all other learning to my sons and to the sons of him who have instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law but to no one else.
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> I will neither give a deadly drug to any body if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to any woman an abortive remedy. In purity and holiness, I will guard my life and my art. I will not use the knife, not even on suffers from stone, but withdraw in favour of such men as are engaged in this work. Whatever house I may visit, I will come for the benefit of the sick, remaining free of all international injustice of all mischief and in particular of sexual relation with both female and male persons, be they free or slaves, what I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about. If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art being honoured with fame among all men for time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.[2]

In 1948, the General Assembly of the World Medical Association effected some modifications to the above oath and it now reads as follows:

> At the time of being admitted as a member of the medical profession, I solemnly pledge myself to consecrate my life to the service of humanity. I will give to my teachers the respect of gratitude, which is their due. I will practice my profession with conscience and dignity; the health of my patient will be my consideration. I will respect the secrets that are confided in me even after the patient has died. I will maintain by all means in my power, the honour and the noble tradition of the medical profession, my colleagues will be my brothers, I will not permit consideration of religion, nationality, race, party politics or social standing to intervene between my duty and my patient, I will maintain the utmost respect for human life from the time of conception, even under threat. I will not use my medical knowledge contrary to the laws of humanity. I make this promises solemnly, free and upon my honour.

After this declaration, the World Medical Assembly at Helsinki in 1964 had to fill the gap to take care of the risk inherent in the subject. In 1970 and 1975, the Oslo and Tokyo Declarations came up with a guide for medical practitioners in their attitude to torture and inhuman treatment or to punishment of persons.

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[2] Adapted from Nigerian Medical Council’s Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria 1980. Se also Okolo, P I, “Medical Ethics in Nigeria, in Umerah, B C (ed), *Medical Practice and the Law in Nigeria,* Ibadan, Longman, 1989, 8 at 14.

The Nigeria Medical Council in line with the above declaration has laid down rules and regulations for medical practitioners towards a patient and where a medical practitioner goes contrary to the rules and regulations, a medical tribunal is set up to try him for malpractices. Medical practitioners are to avoid the following practices: advertising association, addiction, abortion and adultery. When a medical practitioner is found guilty of any of these offences he is deemed to be guilty of infamous conduct in a professional respect.[3]

Two problems arise. One is problem of meaning. What is prohibited in any of the cases above. The thrust of the regulation against advertisement is similar to the ban on lawyers against self-advertisement whether directly or indirectly for purpose of obtaining patients. In this connection a physician may not use others to canvass for business nor should he acquiesce in such a conduct as was in the case of *Allison v General Council Medical Education and Registration*.[4] In that case the following charge was made against the plaintiff, by the society called Medical Defence Union that claimed that being a registered medical practitioner, a licentiate of the royal college of physicians and surgeon of Edinburgh, he systematically sought to attract practice by the system of extensive public advertisements containing his name and address and qualification and invitations to person in need of medical aid to consult him. The court held that infamous it is where a medical man in pursuit of his profession does something, which is regarded as disgraceful or dishonorable by his professional brethren of good repute and competent conduct.

The ban against association with non-medical personnel is strictly ban against co-operating with a person without medical training in treating a patient. This ban covers knowing, allowing or enabling an unqualified person to assist in the management of the sick. The ban excludes nurses, physiotherapists, midwives and dispensers. Addiction to mind altering drug or to alcohol is considered an infamous conduct since it can impair a physician's judgement. A doctor is also not expected by the ethics of his profession to induce a non-therapeutic abortion or to attempt to procure an abortion or a miscarriage either within or outside Nigeria. A doctor's name will be struck off the register of medical practitioners if he has sexual relationship with a patient of the opposite sex.

These rules are enforced by the Medical Council itself but a quite number of legal problems have arisen in the recent past. This is in connect with the court 's strictness on the application of natural justice in a situation where a tribunal or an administrative body purports to make a decision affecting the rights of another without observing the principle of *audi alterem partem* and fair hearing. Moreover, the Supreme Court has held in *Garba v University of Maiduguri*[5] that an administrative tribunal do not have jurisdiction to conduct inquiries or take decisions in a matter involving an allegation of crime. The court's concern for the civil rights of everybody even of those accused of infamous conduct is likely to lead to different results as the following cases show.

In *Denloye v Meidcal Council Disciplinary Tribunal*[6] the appellant appealed against the decision of the Medical and Dental Practitioners' Disciplinary Tribunal which found him guilty on five counts of infamous conduct in a professional respect has ordered the removal of his name from the medical register.

The first count charged the appellant with neglect of a patient for almost a fortnight. The second count charged him with extortion of the sum of 30 guineas from

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[3] Ibid.
[4] [1894] 1 QB 750.
[5] 19 NSCC 306.
[6] [1968] All NLR 306; *Alakija v Medical Council Disciplinary Committee* (1959) 4 FSC 59.

the parent's father in order to induce him to examine and treat the treat the patient. The 3rd, 4th and 5th counts relate to different transactions namely, the receipt of the amount of the £2.2s in each of counts 3 and 4 and £2 in count 5 by the appellant for false pre-employment certification of fitness.

The court gave judgement in his favour on the ground that the withholding of the evidence by the tribunal when the appellant demanded for it constituted a denial of justice to the appellant. For the above reasons, the court set aside the order of the tribunal and restored the appellant's name to the medical register.

Also in *Alakija v Medical Disciplinary Committee*,[7] the court gave the decision of the Committee directing that the appellant's name should be removed from the medical register for a period of two years on the ground that the inquiry was conducted in a manner contrary to the principle of natural justice based on the fact that the registrar who was the prosecutor took part in the Committee's deliberations. The aim of the in- house rules on ethic is to bar the earring physician from practicing medicine. From that angle, it is clear that patients stand to benefit. However, if the misconduct is not actionable, then, in spite of the actual injury, the patient will not benefit directly.

Medical Practitioner's Responsibility

The responsibility of a medical practitioner towards a patient commences as soon the medical practitioner consents to undertake a medical examination of the patient. What is regarded as consent is anything from simple nod of the head or expression of this in words. However for surgical maneuver, a written consent of the patient is imperative before treatment is embarked upon. A medical practitioner must never presume the consent of a patient.

A visit undertaken for consultation implies a request to be examined but the examination of an employee at the request of an employer does not always imply consent by patient. The responsibility of a medical practitioner toward a patient ceases when a patient decides to discontinue with a particular practitioner. However, in cases of discharge against medical advice which patients or their relations request for as a way to discharge very sick patients, the doctor is advised to protect himself with documented evidence of this request. Cases of eventual deaths outside hospital premises have been blamed on unwillingness of the doctor to continue medicare. The professional responsibilities of a medical practitioner require absolute secrecy and commitment.

Aspects of the Law of Negligence

Negligence as a tort is a breach of legal duty to take care of one's patients, which results in damages undesired by the defendant to the plaintiff. Thus its ingredients are

(a) a legal duty on the part of A toward B to exercise care in such conduct of A as falls within the scope of the duty

(b) breach of that duty

(c) consequential damages to B.

The necessary objective attitude of the court to this tort is made clear in what Alderson, B said in *Blyth v. Birmingham Waterworks*[8]

> Negligence is the omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs,

[7] Above.
[8] (1856) 11 Ex 781, 784.

would do or doing something which a prudent and reasonable man would not do. It is not for every careless act that a man may be held liable in law. It is important to examine what a plaintiff who alleges negligence would have to prove.[9]

The most accepted expression of the duty principle is the one made by Lord Atkin in the leading case of *Donoghue v Stevenson*.[10] The plaintiff's friends bought her a ginger beer in a café, she drank some of it and as she was helping her self to a second glass, the remains of a decomposed snail floated to the top of her glass. The nauseating sight of this and the impurities she already drank resulted in a shock and severe gastroenteritis. The case went all the way to the House of Lords on the preliminary issue as to whether a duty of care existed. The question for the House of Lords to decide was: if a company produced a drink and sold it to a distributor, was it under any legal duty to the ultimate purchaser or consumer to ensure reasonable care that the article was free from defect likely to cause injury to health? Lord Atkin stated:

> The English law states that there must be and is, some general conception of relations given rise to a duty of which the particular cause found in the books are but instances.

He went on to lay down the basis of the present law in the "neighbour" principle in this much–quoted passage:

> The rule that you are to "love your neighbour" and the lawyer's question saying 'who is my neighbour' receives a restricted reply. You must take care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neigbour. Who, then in law, is my neigbour? The answer seems to be a person who is so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I was directing my mind to the acts or omission which are called in question.

This statement suggests the existence of a general duty of care towards any one who is likely to suffer injury through the defendant's careless conduct. Even though the rule was propounded in the context of a manufacturer/consumer relationship, it is applied as a general principle beyond the initial context in which it was propounded. This text has proved the foundation upon which countless cases of alleged negligence have been tried and still continue to be judged.

If a duty of care exists then the next inquiry is whether the defendant's conduct was in breach of such duty. The mere occurrence of some misfortune does not as a rule make someone automatically liable. The judge must look at the evidence and decide whether or not the defendant did something he ought not to have done or failed to do that which he ought to have done. How then is the judge to decide whether a defendant is liable? What test can the judge then apply? In *Hazel v. British Transport Commission*[11] Pearce J said:

> The basic rule is that negligence consist in doing something which a reasonable man would not have done in that situation or omitting to do something which a reasonable man would have done in that situation.

After it is established that the defendant owed a duty of care, which he has breached; of which such a damage could be a physical one, for instance a broken leg. The first thing to do is to determine as a matter of fact whether indeed the defendant's breach of duty led to the damage and this is referred to as causation of the facts .The second stage is to determine as a matter of law whether the injury was not remote. This is referred to as remoteness of damage in law.

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[9] W Rogers (ed), *Winfield and Jolowicz on the Law of Tort,* 11th ed, London, Sweet & Maxwell, 1979.
[10] [1932] AC 562.
[11] [1958] 1 WLR 169.

Contractual Negligence

It is possible for a duty of care to arise from an undertaking created as a result of contract. If the patient was treated privately that is if the patient entered into a contractual relationship with his doctor the question may arise as to whether his chances of success are higher in tort or contract. In theory his chances may be higher in contract if the contract was a most unusual one. In such case the doctor guaranteed that the treatment would succeed. But doctors seldom, if ever, make such guarantee and the court would be highly averse to imply any such term to that effect.[12]

Proof of Negligence

It is up to the plaintiff to prove generally those acts or omissions that he claims amount to negligence. What the plaintiff has to prove before a court to hold the defendant liable may in many cases not be available, that is direct evidence. There is also another way in which the plaintiff's task is made easier. This is the doctrine of *res ipsa loquitur* (the thing speaks for itself). The rule can be invoked when the following conditions are met. The injury must be such as does not occur in the ordinary cause of event involving the absence of negligence, the facts proved must point to the defendant as being the negligent party, and there must be absence of explanation.

What is Medical Negligence

This means the failure, on the part of a medical practitioner to exercise reasonable degree of skill and care in the treatment of a patient. If a doctor administers medical treatment to a patient in a negligent manner and causes him harm, the patient can bring an action of negligence against the doctor claiming damages for the harm suffered. A plaintiff must prove the following three conditions in order to succeed in an action of negligence against a doctor:

(a) That the doctor owed the patient a duty to use reasonable care in treating him or her.
(b) That the doctor failed to exercise such care, that is he was in breach of that duty.
(c) That the patient suffered damage(s) as a result of the breach.

Once a doctor undertakes to treat a patient, whether or not there is an agreement, a duty of care arises. The doctor must exercise reasonable care and skill in treating the patient; it is immaterial that the doctor is rendering such a service ex gratia. A doctor in the hospital owes a duty of care to patients in the ward in which the doctor is employed to work, a private physician who has contracted to provide medical services for the employees owes a duty of care to such employees who are on the clinic's list. Medical centers and hospital authorities also owe the same duty of care to patients accepted for treatment in their facilities, whereby they must provide proper medical services for them. Having said this, it must be stated that if a doctor holds out to a patient as possessing special skills and knowledge in a particular field of medicine or surgery, the doctor must exercise the same degree of care and skill as a doctor who generally practices in that field. This is particularly relevant in the case of a doctor, being, for example an obstetrician, undertakes a complicated cardiac surgery, that obstetrician must conform to the standard of a cardiac surgeon. If the obstetrician does not possess the special skills and facilities required for cardiac surgery. Then it is negligence on his part to undertake the treatment at all knowing that as an obstetrician he does not possess the special skills and facilities required for a cardiac surgery. But in an emergency an obstetrician who comes to assist a cardiac patient by performing a simple

[12] *Scott v St Katherine Dock Co* (1865) 159 ER 665.

procedure to ease pain would not be held liable for failing to achieve results that one would expect form a cardiac surgeon.

This standard of care varies according to the skill expected of the individual doctor. A house officer is not expected to show the same standard of skill and care as a consultant working in a special area. A doctor, except in emergency cannot excuse himself on the grounds that he was unwell or he had a long spell of duty and was therefore very tired, the law would hold that a doctor has no business to undertake the care of patient unless he is fit to do so.

The court balances all the relevant circumstances in order to decide whether the medial practitioner's conduct has fallen below what constitutes a reasonable standard of care. He is judged according to what a person in a particular circumstances "ought to have done and person's foresight is similarly assessed according to circumstances and risks which ought to have been foreseen.

Because a practices medicine which requires special qualification, knowledge and skill, must a medical practitioner exhibit a standard of skill and competence in attending to a patient. A standard not measured in superlative but which may be reasonably expected of the average medical practitioner. An example is the "surgeon swab" type of case, where a surgeon in the course of an abdominal operation uses swabs and failed to remove one of them from the cavity before closing the incision. Following the customary practice of nurses to count swabs before and after an operation, the surgeon relying upon this would not relieve himself of liability, since he owes the patient the duty of the care and also it is his duty to supervise the nurses.

Confusion persists as to whether the standard of care is assessed according to the doctor's qualifications, the post within the organisation that he holds or the task that he is engaged in performing. It is submitted that the correct measure is the task that the individual undertakes that fixes the standard, irrespective of his qualification or job title.

It is clear that a surgeon is not liable in negligence merely because an unsuccessful operation has occurred. If it were so, doctors would out of fear of litigation, rarely show that degree of initiative and confidence, which is necessary for the proper exercise of their noble profession. The position was very clearly stated by Lord Denning in this direction to the jury in *Hatcher v Black.*[13] In that case, the plaintiff a singer suffered from a diseased thyroid. She underwent a thyroidectomy after being assured that there was no risk to her voice. A nerve was so badly injured in the operation that the plaintiff's voice was damaged. The doctor knew there was a slight risk to the plaintiff's voice but had told her there was none in order to prevent her from deciding against treatment.

In an action against the doctor for negligence, the learned judge directed the jury thus:

> 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, as a surgeon operating at the instead of getting on with his work would forever be looking over his shoulders to see if somebody was coming up with a dagger for an action for negligence against a doctor. It is for him like unto a dagger. His professional reputation is so dear to him as his body, perhaps. Moreso, 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 inherent in an operation actually takes place or some benefits that were hoped for or if matter of opinion actually takes place or some benefits that

[13] 1958 Times, 2 July.

were hoped for or if in a matter opinion he makes error of judgment, you should only find him guilty of negligence, when he falls short of the standard of a reasonable skillful medical man, in short, when he is deserving of censure.

Conduct that constitutes breach of duty: Breach of duty may take various forms. Examples are: failure to admit into hospital a patient whose condition requires hospitalisation, failure to sterilize surgical instruments, leaving a surgical instrument or swab in the body of a patient after operation, failure to cross match blood before transfusion, prescribing drugs using a patient for experimental purposes without his consent.

A plaintiff cannot succeed in an action against a doctor for medical negligence unless the plaintiff has suffered some harm as a result of the doctor's negligence. It is not sufficient that a doctor was negligent in giving medical treatment to the plaintiff and the plaintiff suffered some harm. It must be shown that on balance of probabilities the harm was so caused. Usually, expert medical testimony is called to prove this causation. This often raises difficult legal problems but the courts adopt a broad approach in resolving them. If the damage would have occurred despite the doctor's negligence, then the negligence did not cause it.

Civil Actions in Courts

Usually for any action, pleadings are filed in court stating facts in relation to the alleged negligence. The doctor will in reply to the pleading also state facts tending to put the matter in a different light. In *Miss Felicia Osagiede Ojo v Dr Gharoro & UBTH Management Board*,[14] the plaintiff's claim arose from a medical or surgical operation performed on her by the defendants, the operation was designed to correct a certain medical condition, but at the end of it, one of the surgical needles used in the operation got broken and the broken part could not be located or retrieved and it was consequently left inside the plaintiff. If it is the fact that a piece of surgical needle being in the plaintiff and the effects thereof as well as the effort to remove it that led to this action. The plaintiff said that after the operation she had serious pain in her abdominal and vagina and she complained to the 1st defendant, who ascribed the pains to the stitches on the site of the operation wound. Four days later when pains would not subside, the 1st defendant ordered for an X-ray examination. The plaintiff said she had two X-rays and the X-rays confirmed that there was a broken needle in her stomach, which was not there before the operation. The plaintiff said the 1st and 3rd defendants informed her that due to the fresh wounds from the surgical operation they could not immediately conduct another surgical operation to recover the needle and also that the 1st and 3rd defendants did not tell her that they left anything behind in her stomach. The plaintiff gave evidence that she saw another gynaecologist who informed her that judging from the way she was operated upon she would be unable to have a child. The defendants admitted the broken needle in her stomach but said the plaintiff was informed after the first operation. The defendants admitted also that nowadays sub-standard needles are being used and that such needles break easily during operations. He denied that the plaintiff could not have any child because of the broken needle in her stomach, that where the needle was located is in the anterior abdominal wall and there was no relationship with pregnancy.

Certain legal questions arose, since the plaintiff pleaded particulars of negligence. One question was whether the plaintiff could still rely on the doctrine of *res ipsa loquitur*. The court reviewed the case of *Management Enterprises Ltd v Otusanya*[15] and *Strabag Construction Nig. Ltd v Oguarekpe*[16] and held that the doctrine could be

[14] Unreportes suit No B/21/94.
[15] [1987] ANLR 250.
[16] [1991] 1 NWLR (Part 170) 747.

pleaded in the alternative. In his judgement, the judge held that although defendants owed the plaintiff a duty of care in the management of her medical problem, the defendants were not negligent in the way and manner they managed her case.

Specifically, the judge held that they were not negligent when they left a broken surgical needle in the abdomen of the plaintiff after a surgical case. The judge went further to say that this was a peculiar case considering the fact that the defendant admitted that the broken surgical needle was still inside the plaintiff's body. The 1st defendant agreed that the equipment for an operation to remove the broken needle was not available to the 2nd defendant's facility. The judge thus said,

> I would have been prepared to grant plaintiff's claim for the estimated cost of this operation on the ground that the defendants having put the broken needle in the plaintiff's body albeit while not acting negligently, they ought to be responsible for the cost of removing it. I am however unable to make this award in view of the lack of evidence to convince the court that this procedure shall remove the broken needle.

This decision gives rise to a number of problems. The defendants said they did not have the facility in their hospital to remove the surgical needle inadvertently placed inside the

plaintiff's body and the defendants admitted using sub-standard needle, why did he have to use it? Is there practice to go ahead with an operation and later claim that it was because it was a sub-standard surgical needle that is why it got broken during the course of the operation?

In *Mrs Deborah Agere & Anor v Dr S Ojobo (doing business under the name and style of Ponder End Clinic*,[17] the plaintiff was claiming against the defendant the sum of one million naira in general damages as well as in negligence for the loss of the plaintiff's first male child, pains, damages, emotional and psychological depression. Loss of life due to the gross reckless and negligent manner in which the defendant carried out the delivery of the 1st plaintiff's pregnancy. The summary of the facts is that, the 1st plaintiff was pregnant and when it was time for delivery she was directed by her doctor to the defendant. The defendant requested the plaintiff to undergo an ultra- sound sensing. Which she did and according to her, the defendant told her she could not have normal delivery, as her pelvis could not accommodate the baby, so, the defendant maintained he had to do a cesarean section for her. The 1st plaintiff went into labour in the defendant's hospital on the 16th of June 1997. After a thorough examination, it was discovered that the baby was in distress. A cesarean operation was carried out on her and thereafter the doctor suggested a blood transfusion because she had low packed cell volume (PVC) but she rejected it on the grounds of her Jehovah's Witness faith. She left the defendant's hospital for Hope Hospital, thereafter for Gilead Hospital where a Jehovah's Witness doctor treated her without blood transfusion. The baby died 3 days after delivery, she then sued the defendant for negligence for the loss of her first male child, pains, damages, emotional and psychological depression, loss of life due to the gross reckless and negligent manner in which the defendant carried out the delivery of her first pregnancy. The defendant denied all the allegations and said it is untrue that he used unsterilised equipment because he personally sterilized two sets of equipment before the operation of the 1st plaintiff. He had earlier explained that he diagnosed that the neck of the cervix was 2 centimeter at 4pm and that the 1st plaintiff was in labour for 6 $^1/_2$ hours whereas prolonged labour is one in excess of 12 hours. The defendant denied the fact that he asked the 1st plaintiff not to push if she loved her self, saying that the art of pushing out a baby at delivery for a pregnant woman was a reflex action,

[17] Unreported suit No B/595/94.

consequently nobody can prevent a woman at delivery from pushing. The defendant went further to say that the baby did not need oxygen. Finally, he explained that the 1st plaintiff came to him 9 days after her expected date of delivery and he was not responsible for the distress of the baby that the baby would have died in the womb if it had been in distress. The defendant said that he and the nurses monitored the 1st plaintiff at all times. The defendant said the operation was successful. The court therefore held as follows:

> There was no difficulty in holding that the defendant owes to the plaintiff the duty of care. Is there a breach of that duty of the defendant to the plaintiff? Nothing in these proceedings has been presented by the plaintiff to show any breach of the duty of care owed by the defendant to the plaintiffs. Indeed the evidence tendered through some of the witnesses of the plaintiff show that the defendant took such reasonable care and discussion in order to preserve the life of the 1st plaintiff.

The plaintiff's claims were accordingly dismissed. It is submitted that the judgment delivered by the court in this case is a sound one since the facts and evidences were thoroughly analyzed by the judge.

From the cases examined so far, one conclusion is inescapable, namely that in a variety of cases, the court cannot attain its purpose of trial without conscientious assistance of medical experts.

Defences Open to Medical Practitioners

Most medical practitioners stand to rely on the defences of consent where there are allegations against them for medical negligence that the patient consented to the treatment forgetting the fact that the patient only consented to proper management of sickness. As the case may be, the law will either imply consent or give the medical practitioner the benefit of the defence of private necessity under consent. Consent that is obtained by fraud is no consent. So also is consent given by a patient who is under the influence of drugs or anesthesia and thus is unable to understand fully what is being consented to. Thus, a doctor is required to give the patient sufficient information about the ailment, the treatment proposed as well as the possible risks so as to enable the patient understand the position fully and make an intelligent decision. The doctor should not minimize the risk.

In Nigeria necessary details are often not communicated to patients. This is due to the fact that because of poor educational background most patients rely on the doctor's judgment for serious cases. Consent must not be obtained by threat of violence or by influencing unduly the patient's will. The majority of hospital's surgical procedures are expressly authorized by the patients having signed a consent form, such a consent will not protect a surgeon from liability for negligence in the course of the procedure, neither will it permit the surgeon to under take a procedure going beyond the consent given or going on a voyage of exploration unless the treatment creates an emergency situation which consent to the additional procedures cannot be obtained immediately. It is to meet this last point that consent forms commonly include consent by the patient to such further or alternative operative measures as may be found to be necessary during the course of the operation.

It is essential for the validity of the agreement, that the patient's consent should be genuine and real; not given under circumstances which would make it not to be a real consent. The practice of obtaining a patient's signature to blank consent forms with the intention of filing in details later is not consent at all.

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. Examples given to this second situation are cases in which the information may cause psychological damage to the patient cases in which the patient is too ill to assess the information properly (more contentiously) and where the information many raise undue alarm in the patient and create a risk of a refusal to accept beneficial treatment. Thus, a physiotherapist has been held to owe the patient a duty to give adequate warning to enable him to know the danger inherent in certain procedure and a hospital was also held liable not to have informed a patient clearly that his treatment was not completed.[18]

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. In medical treatment, the use of experimental procedures is likely to require a full disclosure to the patient of possible risks as well as the provision of an increased level of post operative care. It is clear that the courts approach experimental

[18] *Coles v Reading & District Hospital Management Committee* (1963) Solicitor's Journal 115.

treatment strictly and seek to ensure that a professional person who chooses to undertake such work has considered all the information available on the techniques in question, and has access to the results of empirical research in any question of doubt that remains, and has taken reasonable care to think the problem through so as to attempt to identify any particular difficulties posed by his suggested solution.

The medical profession has been left to set its own standards on the disclosure of risk, except in those rare cases in which a court is prepared to condemn the medically accepted practice as unreasonable. These principles are to be found in the classic statement given by McNair J in *Bolan v Frien Hospital Management Committee*.[19]

Obstacles in the Path of Justice

Some of the obstacles in the way of victims of medical malpractice emerged from interview conducted with victims of malpractice. These obstacles are either procedural or substantive.

The biggest problem the victims to medical negligence faces is finance. This is to enable him undertake legal proceedings against the doctor. Judicial procedures usually require substantial sums of money to prosecute. Either way, the victim will certainly require the services not only of a legal practitioner but also of a medical practitioner as expert witness. Very often, the victims are poor and cannot shoulder the financial responsibility involved in the pursuit of their case. The indigent litigant will because of the high cost, be deprived of his rights to litigate notwithstanding the grave harm that may have been done to him.

Some persons also gave as their reasons for not going to court, the fact that cases do take very long time before it is determined.

Who May Sue

A simple answer to this question can be expressed as anyone to whom the duty of care is owed. Statutes may also confer such a right to some people who were not entitled under common law; for example where death occur as a result of the negligence of another. Every person of full age of 18 years can sue, an infant or minor (not yet 18 years) having a cause of action can sue through his “next friend”, parent or guardian.

Burden of Proof

Section 135 (1) of the Evidence Act stipulates that “Whoever desires any court to give judgment as to any right or liability dependent on the existence of facts which he asserts must prove the those facts exist” while section 136 of the same Act places the burden of proof on the person who would fail if no evidence was given on either side.

In medical practice, the existence of a legal duty of care is of the very essence and presents no difficulty. That there has been a breach of that duty, which may be presumed by the mere fact that the plaintiff has been injured or harmed *(res ipsa loquitor*) but that the injury suffered was a direct consequence of the breach may be difficult. The defendant is not required to prove that he exercised such skill and competence as it would be reasonable to expect from a medical practitioner of his class (that he was not in fact negligent), the law will presume this. The onus of proof lies on the plaintiff; the burden is not so heavy as consideration of the criteria of proof would seem to indicate. The problem of proving medical negligence is peculiar since some of the harm is slow to manifest and their symptoms only become noticeable long after the breach.

[19] [1957] All ER 118, 221-2.

Damages Awarded by Courts

Damages are awarded for the injury itself and the consequence of the injury such as pain and suffering. The damages should be such that the ordinary sensible man would consider fair in the circumstances. For a successful claim for damages, a victim must establish that he has suffered a legal injury by the acts or omission of the defendant which has resulted in loss to him. Such a loss must however be attributable to the acts or omission of the defendant. Damages are either compensatory, special, aggravated or exemplary.

Conclusion

Attempts were made in this article to discuss what constitutes negligence as well as what constitutes medical negligence, the attitude of the courts when such cases are before it and the obstacles faced by victims in trying to seek redress in the court.

In some cases, medical negligence may be the result of inexperienced doctors, so it is important to state that not all doctors who have graduated from the university be allowed to manage certain types of ailments or allowed to open a clinic immediately after leaving the university.

The Nigeria Medical Council should lay down standards of fitness to practice and also exercise discipline over the medical practitioner whose professional negligence is an embarrassment to the council as was done in the case of *Dr (Mrs) F C L Olaye v Chairman Medical and Dental Practitioner Investigating Panel & others*.[20]

It has been discovered that the Professional Conduct Committee is only concerned with serious matters of professional misconduct and does not provide any protection for the public. The courts in cases of permanent disability or harm, applies the penal sanction on the criminal aspect that acts as a punishment and has a deterrent effect, but the victim is still left without compensation, because the penalties or fines are usually for the state. The victim then has to seek compensation by way of a civil action and I will urge the courts to make history by awarding heavy compensation. However, in view of the problems of finance faced by the victims, our judicial system should be reviewed to allow courts which determines the criminal aspect of medical negligent to award compensation to the victim directly. Thereby removing the necessity of a civil action by the victim.

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.

In the United Kingdom and the United States of America, there is the compulsory insurance policy, which every hospital should subscribe to in the event that there is medical negligence so that the hospital may be indemnified in such a situation. This scheme in Nigeria will promote settlement procedure in medical negligence and the victims would thereby be compensated for the negligence of the hospital.

[20] [1992] 5 NWLR 553.